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THE CITIZEN WORKS FOR MENTAL HEALTH *

I. HE TAKES ON A SERIOUS JOB—PARTICIPATION

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"WORKING for mental health brings about new understanding within the worker himself." This statement, given in the program as our theme at this session, rightly implies that if the citizen works for the mental health of others, he will himself achieve more adequate mental health. Every citizen should consider it an obligation of citizenship —yes, of survival—to work for the mental and emotional well-being of all his neighbors as well as his own. If this responsibility is to be realized, it will be necessary to do something quite practical about the unique rôle the citizen accepts when he tries to "take on" this "serious job."

Let us recognize from the start that the citizen does participate in everything that is done for better mental health—he pays the bill. Voluntary contributions or those levied through legislation support all the efforts of psychiatric and mental-hygiene workers, whether or not the citizen ever personally and directly benefits from these often obscure and unknown investments in an intangible part of his environment. Citizens, lay and professional, contribute financially to the support of programs such as that of The National Committee for Mental Hygiene. Taxation provides for the services of the various state governments in the improvement of

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public mental-hygiene preventive programs, and it is good to note that they have been strengthened in recent years. Taxation provides for the services of the United States Public Health Service, which is making available, through appropriate channels, considerable appropriations for the support of research and professional-training programs, to produce more and better prepared psychiatrists and mental-hygiene workers. These developments should be unceasingly encouraged, for they will certainly affect the future quality of professional services available to our citizens. Such a limited concept of citizen responsibility, however, is not enough. It has become very easy to salve our social consciences with monetary contributions alone. "Taxation, voluntary or legislated, without representation," and participation in preventive mental-hygiene programs, is an inadequate concept of the citizen's right and responsibility. It is necessary for those concerned with mental hygiene to promote and establish by principle and example a citizen's program for preventive mental hygiene as an integral part of every phase of community living.

It is well here to note the suggestion of Dr. Alan Gregg in his address at the luncheon meeting of The National Committee for Mental Hygiene in 1947. "We have not enough professional psychiatrists, psychologists, and psychiatric social workers," Dr. Gregg stated, "nor have they time enough, to make mental hygiene a reality unless we can find large numbers of laymen to join us. We must learn to work together."[1] There is the nub of our most important mental-hygiene and educational need. The people appreciate this and want to do something about it. We must meet the demand for the skills of coöperative planning and action, for these will have much to do with the manner in which all citizens undertake this serious job of mental health.

The form of mental and emotional taxation levied upon our citizens cannot be measured in dollars alone. The price of inadequate mental health must be measured in social terms of inefficiency, physical pain, anxiety, and travail. Moreover, our citizens are too often socially and politically numb with the perplexities of their personal and community problems,

[1] MENTAL HYGIENE, Vol. 32, January, 1948. p. 1.

of the atomic age and world unity, to feel either free or able to do much about their own troubled thoughts and feelings of anxiety, let alone those of their fellow men. We must cultivate the desire of our citizens to work together for mental health and their confidence in their ability to do so.

Although the lay citizen has taken quite seriously his financial obligation to support mental-hygiene programs, he finds little opportunity to participate personally in preventive mental-hygiene work. Citizens must strive to overcome their feelings of unimportance, inadequacy, and isolation by active participation and thereby achieve personal therapeutic gain. Regular and repeated visits to a mental hospital or a lonely patient will be "twice blessed"; they are beneficial to the visited and to the visitor. Citizen participation need not be large-scale or sensational to produce a better mental-hygiene program or a new understanding within the citizen himself.

Mental-hygiene work is sometimes considered to be the exclusive province of the specialist. An examination of mental-hygiene programs, whether supported by voluntary contributions or by public funds, reveals little or no opportunity for citizens to learn how to work with the professional, or how to work together as citizens, regardless of professional status, in unified social action for the improvement of the mental and emotional climate of the local community, let alone their own state of being. We hardly ever consider the mental-health implications of the agenda of the town council or the school board, but they are present in every item of business. Citizen participation can begin at home. The professional mental-hygiene worker and the layman must learn how to work together. Lay citizens sometimes have their enthusiasm for participation quelled by the professional status of the specialist. The lay citizen's rôle is a unique rôle, one that the specialist cannot fill, and the layman need not feel handicapped either by inadequacy or by his lack of professional status.

Leadership and financial support will no doubt have to be assigned to the task of assisting laymen and mental-hygiene specialists to get together and learn how they can work effectively and coöperatively with professionals of all disciplines

in the promotion of local and national social action. Dr. Robert L. Sutherland, Director of the Hogg Foundation for Mental Hygiene in Austin, Texas, recently stated, "A sense of participation is a mental-health asset to a person or a group. Largely because community workers have not developed skills in group methods, we are forever and a day setting up a well-intended organization, but failing to develop program and opportunities for participation. The training of inconspicuous leaders in philosophy and methods now well known in the field of group dynamics would multiply infinitely the mental-health opportunities for participation throughout the country. Possibly the next need in mental-hygiene societies is just such training in group methods."[1] Effective citizen work for mental health is not an accident. It requires planning, preparation, and democratic community-problem-solving skills.

The professional worker in psychiatry, mental hygiene, psychology, and other disciplines is primarily concerned with therapy. He has worked in an exclusive manner, and often for all practical purposes deprives the layman of his birthright to do something about his own mental-health needs, if he expresses a proprietary attitude. Disregarding the non-professional and charlatan efforts to cure men of their mental ills, let us examine what difficulties legitimate professionals present. Within the metropolitan area during the past year, professional psychiatrists openly discouraged lay groups from developing local programs dealing with mental-health needs. In a nearby state, psychiatric social workers strove to prevent citizens from planning for local action because they, the citizens, did not have a "professional point of view."

Granted that there are "quacks" at work in our towns and cities, nevertheless the professionals have been too quick to label and too slow to capitalize on local interest and initiative in a constructive manner. Many professionals do coöperate and work with laymen, generously contributing time and effort without charge, to no avail because they cannot refrain from patronizing mannerisms and from talking "down" to the laymen. The professional mental-hygiene programs need more than the layman's dollar support. They need his sup-

[1] Quotation from a letter to the writer.

port in the elimination of fear of diagnosis and treatment, and fear of the concepts of mental ill health which threaten his status in the community. The professionals also need the support of these lay citizens in their home and family living, in the shops and mills, and in the village square and gossip circles; otherwise all of the professionals in training and in preventive mental-hygiene programs will never get beyond the front gates of our communities.

To-day the literature is filled with research for rapid-treatment methods. Everything from lobotomies to vitamins are inappropriately promised as a panacea when stretched beyond their proper sphere. Scientific discoveries and techniques for the diagnosis and treatment of mental and emotional ill health cannot alone reduce either the morbidity or the mortality of these causes of sickness and death. As Mr. David Lilienthal has so clearly indicated, "Learning how to make scientific advances serve mankind, and how to make them part of the stream of man's everyday living, is even more important than the solution of technical riddles."[1]

In the nineteenth century, tuberculosis was a major cause of death. In 1890, Robert Koch tried to develop a therapeutic tuberculin which was one of the antecedents of many modern serological techniques utilized to diagnose the presence of infection. Soon after Koch's discovery, Wilhelm Roentgen made discoveries that led to modern X-ray techniques; these are also now widely utilized in the diagnosis of tuberculosis. These two important discoveries were not enough to bring to attention the nation's tuberculous because the people had to overcome individually their fear of the procedures involved and of possible social censure before they could be brought to seek treatment. This latter step was accomplished through local lay education and action. When the laymen and the professionals in every county, town, and hamlet were organized and enlisted in the work of a local early-diagnosis-and-prevention committee, it was possible to utilize the technical advantages of modern science. It was thus the participation of the citizen that made him do something about his own tuberculosis.

[1] *This I Do Believe*, by D. E. Lilienthal. New York: Harper and Brothers, 1949. p. 37.

Modern mental-hygiene and psychiatric services are deeply rooted in the ethics and practice of medical science. The respectable psychiatrist, mental-hygiene specialist, or clinical psychologist protects his privileged communication. This is as it should be in the diagnosis and treatment of physical disease and of mental and emotional ill health. However, this "dyad" relationship of the therapist and the patient has been perpetuated in nearly all considerations of our national mental-hygiene needs. Certainly this seems to be true in many of the present preventive efforts. A plethora of speeches fill the airways; an abundance of printed matter prescribes sound concepts of personal and social mental hygiene; and innumerable agencies assume the rôle of the expert; and, with the best of intentions in the use of such media, their spokesmen often confuse laymen with conflicting diagnoses and recommendations. Professional inconsistencies will not inspire confidence or motivate action among the citizen allies who are not professionals. The interested lay citizen would like the specialists to distinguish the preventive mental-hygiene functions and services from those that are diagnostic and therapeutic in nature. The intelligent layman realizes his incompetency in these latter areas of mental-hygiene science, but he should be helped to believe that he has a part to play in the prevention of further mental ill health. At the present time, with a few exceptions, preventive thought and program planning, in the fields of public-health education and mental hygiene, are based upon concepts of teacher-pupil relationships and the uni-directional privileged communication of the therapist with the patient. We need a new concept of preventive mental-hygiene work and program planning as something quite different in nature from diagnostic and treatment activity. It is well to heed Dr. Allen's word that we have not time or sufficient voices to achieve a door-to-door campaign of prevention. *We have no choice but to get the citizen working for mental health and for a new self-understanding and acceptance.*

The Socratic method of education utilized by Mark Hopkins would be most desirable if there was a sufficient number of trained and intelligently sensitive specialists who could and would assume responsibilities for preventive education. The

specialists have neither the time nor the skill to carry on a widespread educational program essentially preventive in nature. To expect them to do so at this time would seem to be unreasonable. If the citizen is to be enlightened and enlisted in this "serious job" of mental hygiene, the specialists will have to do more than exhort or preach about sound mental health.

Dr. Goodwin Watson, in his study, *Action for Unity*,[1] has stated that, in so far as the layman is concerned, the specialists would do well to "let the exhortations be few; let the resolutions be reserved for those occasions when, with specific choices in view and a full understanding of the consequences, some individual or group or organization (for laymen) is determined to undertake a more constructive policy." The Commission on Community Interrelations has made similar discoveries in its studies of prejudice and discrimination, problems that are basically mental and emotional in origin.

A democratic and productive form of citizen participation in preventive mental-hygiene work is imperative for a vital government and a dynamic citizenship. Participation must be more than voluntary or legislated taxation, either financial, mental, emotional, or physical. If the full and long-term support of our lay citizens is to be applied to current mental-health problems, it will be necessary to do even more effectively and economically, in a broader sphere, what is being done in the prevention, diagnosis, and treatment of tuberculosis, cancer, and poliomyelitis. Able laymen must be recruited, enlisted, and trained to carry on the serious job the citizen ought to do for the most effective social action of our century in preventive mental-hygiene programs at the local level.

The more recent developments in knowledge and skills in interpersonal relations and in community action provide promising resources of help in the promotion, achievement, and integration of effective preventive mental-hygiene programs. The multi-professional approach to the world's mental-hygiene problems is a sound beginning in coöperatively organized thought and action, as developed in the World Federation of Mental Health. This, however, is not enough.

[1] New York: Harper and Brothers, 1947. p. 30.

Until the professionals and the semi-professionals can sit down together with responsible, confident, and respected representatives of all the social and cultural groups in the community in face-to-face relations, and creatively and productively work together, we cannot involve the laymen in this "serious job."

The first steps must no doubt be taken by the professionals. Dr. Elton Mayo, of Harvard, has clarified this major problem in his report on the Hawthorne Experiment. "The failure of collaborate effort within the nation, . . . a symptom of social disorganization, is far more significant than the emergence of black spots of crime or suicide upon the social geography."[1] Dr. Mayo continues, in his conclusion, with what for many is the reality of the layman's relation to the professional mental-hygiene or psychiatric specialist. "Our administrative (or professional) élite . . . is the élite of yesterday. It faces the problems of the present with . . . the outworn weapons of yesterday. The chief difficulty of our time is the breakdown of the social codes that formerly disciplined us to effective working together. For the non-logic of a social code, the logic of understanding—biological and social—has not been substituted. . . . We have too few administrators alert to the fact that it is a human social and not an economic problem they face. The universities of the world are admirably equipped for the discovery and training of the specialist in science; but they have not begun to think about the discovery and training of the administrator."

The administrator of the preventive mental-hygiene programs of the future is the citizen who is ready and willing to take on the serious job in the local community, and as he does so, his competence will increase.

The critical work in mental hygiene that needs to be done can be done only by the citizen, with the assistance of the professionals. Unfortunately more often than not citizens leave these critical tasks to agencies and professionals and become rusty in their citizenship. If this process is to be reversed, citizens must act. The critical areas will then be relieved and citizenship will have new meaning.

[1] *The Human Problems of an Industrial Civilization*, by E. Mayo. New York: The Macmillan Company, 1933. pp. 177, 188.

II. HE GOES THROUGH THE MOTIONS—LULLING

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TO judge from my title, my assignment is to give the public hell. Remembering, however, the wise words, "Let him among you who is without sin cast the first stone," I'll deal with criticizing very lightly and quickly and then try to accentuate the positive aspects of my subject.

All of you have given thought to mental hygiene and to what it involves. Essentially, mental hygiene is like public opinion. It exists only as the sum of a collection of individual attitudes and feelings; thus we influence it only by influencing the individual.

And just as the leaders of the political parties found out long ago that the crux of their task was to get out the individual votes, so the success of the worker in mental health depends upon his ability to influence single individuals. The politicians rely on the small municipal, state, or federal job-holder—the elevator man in the courthouse—to induce those close to him, his family, and his neighborhood to see the light. The best results in mental hygiene also come from contacts close to the grass roots.

Your own contribution to this end, like that of the vote-getter at election time, depends upon the number of individual people you can influence. Also, like a vote-getter or a magnet, the power of your influence diminishes in proportion to the square of the distance from the objective.

An individual may be said to have mental health when his satisfactions outweigh, in his own estimation, his dissatisfactions and frustrations. Viewing the problem simultaneously as a national and an individual one, what ways are available to us to promote mental hygiene? It would appear that there are three possible channels of effort: we can (1) add to the individual's satisfactions, or (2) eliminate his frustrations, or (3) induce him somehow to reassess his situation, so that he may squeeze more out of its assets and relegate the disagreeable side to its proper perspective.

From what has been said, it should be clear that the greatest pay-off for your own individual efforts in mental hygiene will come from your children, spouses, and neighbors. If all of us practiced individual mental hygiene, we'd need no national movement. Our very presence here to-day as part of a group effort points up our individual shortcomings. Let us pause to examine how well we are helping our families and neighbors to squeeze the juice out of their satisfactions and deal constructively with their frustrations.

Lots of our interpersonal difficulties seem merely habitual and unnecessary. It's like the story of the Hatfields and the McCoys. Some one asked the then current chief of the Hatfield clan, "Why don't you bury the hatchet and make friends?"

"I wouldn't mind making friends," said Hatfield, "and besides McCoy is a right nice fellow, but think what my sainted father would say!"

The very statement of interest in mental hygiene—the statement that you wish for a happier life adjustment for people in general—implies that you love your fellow man and that you believe in him. I am confident that all of us gathered here to-day do feel just that way. But are your efforts in this direction paying off? Are you accomplishing this objective in the area of your most powerful influence—your own neighborhood? An unkind attitude toward Mrs. Fidich on the floor above and her tippling husband and noisy children will outweigh a dozen pageants and bazaars given in the interest of brotherly love. It even outweighs a $50.00 contribution to The National Committee for Mental Hygiene.

Why do we take such unfriendly attitudes, anyway? It appears that there is something in us that works against us. Man seems to have a natural impulse to be mean to his fellow man. Have you ever seen the cruelties that a group of children can visit on another youngster? We don't know why it is, but this destructive impulse comes naturally. We don't understand it altogether, but it has something to do with a fear of the unfamiliar, and it works against us. Instead of ignoring it, it might be profitable to study this basic urge and see if it could not be turned into something more useful. Certain things have been done with it. It appears to be at

the bottom of school spirit, of political rivalries, and even of nationalism. Living in comparatively separated families, communities, and nations as we do, we develop certain intramural customs and understandings, mores that ultimately become powerful cultural pressures.

Many of these things within us are habits ingrained by tribal custom, the patterns of our cultural group. Cultural pressures produce in us many obvious paradoxes that we often don't bother to recognize. Most men, for example, if the matter were being brought up for the first time, would not consider wearing two layers of tightly buttoned shirt and a knotted tie around their necks while struggling through a working day in midsummer heat. And yet they all meekly obey the dictates of custom. Frenchmen urinate in almost open accommodations at street corners. Not that they are very different from American men in their needs, their values, their hopes and fears and aspirations, but their tribal customs are different. Many an American male who at first blush considered this practice disgusting and beneath him has embraced it as a sensible convenience after a few weeks in Paris.

Southerners don't differ much from Northerners as specimens of *Homo sapiens*, but their cultural pressures and customs differ. Often customs and cultural pressures force us to do things—destructive things—that are really contrary to our own basic convictions. They often rob us of what John Dewey considers a personality's most important ingredient —belief in one's fellow man. Belief in him means wishing him well. There is hardly an American who does not subscribe to this feeling, and yet many of us heap unhappiness upon our fellows by humiliating them. Habits and customs induce us, despite our basic benignancy, to brew, by our illogical bias, the cup of bitterness for Jews and Negroes and others of our fellows. Cultural pressures are powerful, and transgressing them may reduce a strong man to sickness.

Leo Simmons, professor of anthropology at Yale, tells of an observation among the Hopi Indians in New Mexico. The Hopi have a code of non-violence and it is the most serious kind of infraction for a father to strike a son. Well, a recent Hopi chief was provoked beyond endurance by his young son,

who had discarded much of the old Hopi culture as useless superstition. In a fit of anger, the chief struck his son. The boy readily forgave him and dismissed the incident, but powerful cultural pressures were not to be so readily brushed off. The chief became violently ill, vomited for days, suffered intense abdominal pain, and was altogether unable to eat. He rapidly lost weight and strength and did not recover from the illness until he had been brought close to death. In his culture this drastic physiological shake-up was necessary to purge his whole person of such an unwarranted flouting of his traditional cultural patterns.

When I was in New Guinea during the last war, I was for a brief time medical consultant for a small native hospital. There, dying in one of the beds, was a silent and terrified man who had been bewitched by an ill-wishing fellow clansman. The hostile neighbor had mixed a certain potion and uttered incantations. Our patient had not drunk the potion or even seen the man. The man had accomplished this ritual alone. That was all that was needed, however; our patient had had *pouri pouri* made against him, and he died. I saw the autopsy on that man. He had died of the superstition and prejudices of his tribe.

That is a dramatic tale, but you don't have to go to New Guinea to witness such psychosomatic phenomena spreading illness and even death among us. In the laboratories of the New York Hospital Cornell Medical Center for the past ten or fifteen years we have been studying the bodily disorders and diseases that constitute part of an individual's attempt to live constructively with his environment. Thus far we have evidence that the stomach may become chronically underactive under the stress of interpersonal relationships, so that its content remains undigested and ferments uncomfortably below the breast bone, leading ultimately to nausea and vomiting. Or in other situations the exact opposite may happen, the digestive activity of the stomach becoming so intense that it ultimately digests its own tissue. A patient suffering from such a painful peptic ulcer may die of perforation or hemorrhage.

Moreover, during the course of studies on the membranes of the nose, it soon became apparent that frustrating life

situations were responsible for stuffed-up, running noses as often as other causes. This led us to a very revealing set of experiments.

A group of healthy subjects were selected some of whom were subject to occasional nasal troubles. First, they were asked to inhale the fumes of aromatic spirits of ammonia. This produced a violent reaction in the nose—swelling of the membrane, with obstruction to breathing and a stream of mucous secretion. This was no surprise, and it was no surprise when the noses behaved the same way in an atmosphere of smoke and gas fumes. The whole thing seemed like a natural way for the respiratory passages to protect themselves from harm by shutting out, washing away, and diluting the noxious atmosphere.

Next, we exposed our subjects to pollens to which they were sensitive, and again got the same reaction.

Then the subjects were exposed to another kind of threat to their integrity in the form of a constricting steel band applied around the head. This was a powerfully disagreeable experience and though it represented no threat to the naso-respiratory apparatus, it nevertheless called forth this same reaction of shutting out and washing away.

Finally, an attempt was made to see whether or not symbolic threats that did not involve any physical contact would call forth the same responses. Accordingly, a forty-two-year-old salesman, a chronic sufferer from nose trouble, was examined at a time when his nasal structures were normal. Suddenly he was reminded that he was caught in the toils of an unfavorable marriage and that his wife considered him a meal ticket and gave him nothing in return. His nasal membranes promptly began to swell and run and shortly his nose was in the same condition as after the ammonia fumes. Thus it would appear that a biologic pattern of defense appropriate against smoke and fumes is invoked somewhat inappropriately against other stresses and threats to the individual's security and integrity.

The occasional use of such a device for brief periods probably causes little difficulty, but sustained nasal obstruction from whatever cause can lead to pain and infection of the nasal passages and sinuses.

Other psychosomatic disturbances similarly reflect the use of protective reactions involving some organ or organ system which may be appropriate against certain chemical and physical assaults, but are less so against the symbolic threats that call them forth. When adopted as a way of life, such patterns may lead to serious disease and even death. In this connection evidence has also accumulated relating blood clotting, asthma, intestinal troubles, high blood pressure, and diabetes to the "slings and arrows of outrageous fortune," to man's blocking of the development and fulfillment of man's potential.

Never was there written a couplet containing less truth than, "Sticks and stones may break my bones, but words can never hurt me." And yet, in line with the habits of our tribe, that couplet has been on the lips of most of us. If sticks and stones were our problem, it could be easily licked and there would be no need for us to gather here to-day.

As I have already emphasized, most of us wish our fellows to be happy and well adjusted, although we daily subvert these aims by hundreds of habitual acts, from glowering at other motorists to making a fortune by driving a competitor to the wall and to bankruptcy. Fortunately for us, however, our culture also provides convenient and habitual salves for our conscience, lest it should happen to prick. These, of course, are forms as empty as the ritual of a voodoo tribesman avoiding the evil eye, but they are equally—in fact, superbly—effective. Just as passing communion in church will absolve the most shrewd and ruthless tycoon of any possible qualms of guilt, so will a benefit sale, a lecture course, or even a committee meeting do the same for his snobbish and intolerant wife.

The job of mental hygiene is to deal somehow with our individual and community attitudes. Perhaps this will involve bringing our cultural values into line with our spiritual values. That is no easy job and it is not the subject of my presentation. Active and vigorous participation, along the productive lines outlined by Dr. Herrold, will do much. Careful attention to our individual impact upon those close about us may perhaps do more. But somehow I believe that we need to study in more detail the natural forces within us that lead to

the many destructive cultural patterns we have evolved, so that, like water and fire, they may be harnessed for more constructive ends.

There is a popular young minister here in New York who at the close of each service offers the following prayer. I can think of nothing more appropriate as a watchword for those of us who are interested in mental hygiene—in a happier adjustment for ourselves and our fellow man.

"Our Father, grant that what we say with our lips, we may believe in our hearts; and all that we believe in our hearts, we may practice in our daily lives."

MENTAL HEALTH IN INDUSTRIAL RELATIONS

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BOTTLENECKS in business and industry were for many years technological. Advances in tool construction and plant layout are still to be made, but management is now turning its attention to a more serious slow-down factor—the variability of human behavior.

At one time, business and industry tended to govern the human material by a rough-and-ready personnel policy of "take it or leave it," but war-time labor shortages, the power of unions, and the enlightenment of management have all contrived to make this policy outmoded.

The newer approach calls for an understanding of worker attitudes, for a knowledge of group morale, and even for psychological insight about top management itself.

When the desire to understand human variability first entered the minds of business and industrial leaders, it was accompanied by the hope that quick and certain explanations about human behavior would be forthcoming. Aptitude and other vocational tests looked like the sure way of weeding out the unfit and of properly placing those who were accepted. Personality tests were the new way of measuring qualities of leadership among supervisors and top management. Technological problems had been solved scientifically, so why could not problems of human nature yield to exact methods as well?

Uncoöperatively, human nature failed to respond, or to be encompassed by these "scientific methods." The approaches named had value, but were only a partial answer. They did not account for enough human variables. They forgot, for example, that the attitudes of a work group toward a foreman may be as important in determining output as the workers' aptitudes and vocational training. They forgot that while people can be organized on a chart, the intangibles of how they feel about their job, as well as how they are adjusted

in their off-the-job relationships, will determine their performance. Disillusioned by the failure of these early methods to give the full answer, business and industry are in a welcoming mood. They are anxious to accept ideas and help from any discipline that has insight about human behavior. Mental hygiene is proving to be one of these sources.

Unaccustomed to this new courtship, mental hygienists found themselves at first little prepared to give practical help in economic matters. Their principles and skills had been proved useful in understanding children, family relations, and morale in the classroom, but now they were asked to enter the factory and the office to deal with basic problems of production.

Fortunately, the transition has been made with surprising speed. The mental hygienists' understanding of the emotional needs of people, the causes of frustration and discontent, the reasons for antagonistic and rebellious attitudes, and the ingredients of positive satisfactions and high morale are proving to be applicable to a work group as well as to any other. These principles help foremen understand that their own reactions and those of their workers are not what they seem on the surface, but reflect patterns that have developed over a period of years, and that change slowly because they serve the individual emotionally.

The mental-hygiene point of view also has shown that business and industry themselves have a responsibility in creating better opportunities for good housing, recreation, improved family relations, and greater social satisfactions on the job; that people who grow up in such a positive environment are much freer of antagonisms and compensatory forms of behavior.

At one time, a factory superintendent thought that high absenteeism and low morale were caused by general states of mobility and unrest in the community. He expected schools, churches, and welfare agencies to stabilize families in order that business might have a dependable work group, but now he sees that management is in the partnership. Dr. Elton Mayo, of Harvard, has shown that social satisfaction on the job, the dynamics of group interaction, the rôle of the foreman as a group leader—that these become a new concern and

a challenge to management.[1] The training of supervisors in an understanding of these matters is a joint undertaking. Contributions are made by clinical psychology and psychiatry, but also by cultural anthropology and sociology, as well as by religion and education. Research studies set up by industry itself utilize all of these approaches in understanding "why people work." This team approach is slower, but less likely to omit important factors.

The mental-hygiene point of view has a second contribution to make to business and industry—that of helping supervisors and union leaders deal more intelligently with certain "cases of abnormal behavior." The guard who stays awake on the night shift only with superhuman effort, the overly sensitive worker who flares back at the slightest criticism, the "eager-beaver" worker who overpromises, the hypochondriac, and many others—these types of behavior cannot be dealt with on the surface, but only through a basic understanding of the emotional drives involved.

Many companies are finding that a consultative relationship with the community mental-hygiene clinic is valuable. Others have found it worth while to add a psychiatrist or a clinical psychologist to their own staff. Still others advise that the greatest value comes in a broad educational effort to improve the insight of all supervisors into the emotional needs of people and the various manifestations of that need. Such education of supervisors is carried on by a psychiatrist or a clinical psychologist, and the preventive work with individuals and groups is done under the guidance of such an expert.

The third contribution of the mental-hygiene point of view is to management itself. Self-discipline and high-pressure output are responsible for the arrival of many superintendents at the top rung. This very drive may have made the individual blind to his own intolerances. Harmony does not always exist among top-bracket supervisors any more than it prevails between management and labor. Supervisory wheels can be skidded because of unnecessary jealousies, short tempers, high fatigue, poor placement, or a sense of

[1] See *The Social Problems of an Industrial Civilization*, by Elton Mayo. Boston: Division of Research, Graduate School of Business Administration, Harvard University, 1945.

inadequacy for the job. Top management is now realizing the need of psychological consultation help. It is provided by a staff expert, or by an outside consultation group of psychologists or psychiatrists, or by experts located in a nearby clinic or university center.

No utopia has been found; the more we know of human nature, the more complex it becomes. Nevertheless, mental hygiene, accustomed as it has been over the years to a team approach to any problem of human behavior, does have a distinctive contribution to make in this new and most important field.

THE TRAINING OF PSYCHIATRIC NURSES IN AN OUTPATIENT CLINIC

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A CURRENT experiment in teaching social-work discipline to nurses is providing an important demonstration of how one profession can be interpreted to another. The setting is the Western Psychiatric Institute and Clinic in Pittsburgh, which has for its purpose the study of mental illness from the point of view both of research and of teaching. It has recently undertaken, as part of its nurses' training, a program of short-time affiliation of advanced mental-hygiene consultants with the social-service department. The consultants are all working for a master's degree in nursing.

The institute consists of five different departments interrelated by the common purpose of achieving a comprehensive understanding of the patient. They are the medical department, the nursing department, the social-service department, the psychology department, and the occupational-therapy department. Each carries on a program of professional training.

The medical department trains physicians in clinical psychiatry in a three-year program. The nursing department offers a three-months affiliation to undergraduate student nurses from other hospitals, in which they gain knowledge of psychiatry and experience in psychiatric nursing. It also provides experience for graduate nurses working toward a bachelor's degree with a major in psychiatric nursing, as well as for the mental-hygiene consultants, who are recipients of U. S. Public Health Service scholarships. The social-service department trains students from the schools of social work at Carnegie Institute of Technology and the University of Pittsburgh. The psychology department trains clinical residents in psychology, and the occupational-therapy department pro-

vides experience for students in occupational therapy from Ohio State University. The departments all work together in interpreting the different disciplines to the students.

The social-service department began its program for mental-hygiene consultants as a result of a request from the School of Nursing of the University of Pittsburgh. The school asked the institute to train the third-year mental-hygiene consultants in some of the techniques of interviewing. As a consequence, these nurses were assigned to the institute's social-service department for two and a half days each week during a semester. Their work has been confined to the institute's outpatient clinic, which receives cases referred for diagnostic purposes and treatment from private practitioners. The supervisor of intake in the social-service department selects for the training program those cases which she believes the nurses can work with most comfortably, and which do not indicate a need for a continuing relationship with the clinic—cases involving diagnostic work, but not long-time treatment.

As the diagnostic clinic is used as a teaching medium for all professionals, these cases are referred to the medical students after the nurses have worked up a complete diagnostic history with a relative or friend of the patient. Clearance with the social-service exchange is a routine procedure. Therefore, it becomes the nurses' responsibility, not only to interview the relative or friend, but also to read, evaluate, and weigh the material obtained by other agencies and prepare it for presentation at the diagnostic outpatient conference. This conference consists of a case discussion by the clinical director, the senior psychiatrist, three medical students, three mental-hygiene consultants, who have prepared the histories, the director of social service, the instructor of nurses assigned to social service, the supervisor of intake for the outpatient department, and the psychiatric social worker who is the liaison between the outpatient clinic and the ward service. After a medical student has presented the chief complaint, the nurse gives the diagnostic history.

There is no intention, either on the part of the institute or of the school, to make the nurses who are preparing these histories into social workers. The purpose of the program is to enlarge their vision and horizon by giving them the

experience of direct work with persons who seek help from the outpatient clinic for their relatives or friends. The depth to which their training goes is determined primarily by the interest that the individual nurse brings to the experience. This varies, as each of the nurses has a different background of professional experience and practice, as well as a personality that is distinctly her own. In the assigning of cases to the nurses, the intake supervisor takes their individuality into consideration and also tries to give each nurse as varied an experience as possible.

The nurses, on their part, are making an honest attempt to understand what social work, as a discipline, has to offer in bringing about a vital understanding of the patient. In doing so, their thinking is apt to go through many phases. The profession of psychiatric social work is often not understood by other professional workers. The nurse sees how the social worker would react in a situation in which she works *with*, but does not feel *like*, the relatives with whom she is working. One nurse recently remarked: "I can see now how little the psychiatric social worker does in a 'doing sense,' and how much she understands, which makes this so different from what we ever dreamed social work was, as a profession."

All the nurses in the group have had some degree of other contacts with social work. In this program it has been decided to limit their experience of the social-work function to the performance of the psychiatric social worker as it exists in a particular clinical setting. Here the functions of the psychiatrist and the psychiatric social worker are clearly defined, the psychiatrist working with the patient around intrapersonal problems and the psychiatric social worker working with the relatives and the patient around interpersonal problems.

Along with their actual practice in taking case histories, the nurses participate in a series of group discussions in the technique and art of interviewing, led by the director of social service. The discussion at first centers around the meaning of the material requested in the social history. Usually they do not feel free enough to ask many questions about this until they have actually conducted their first interview. Their first material is usually unimaginative, lacking in color, and

objective to the point where there is no feeling conveyed through it. It is rigid and very much like a doctor's cut-and-dried prescription.

The nurses describe, in detail, how they have approached the person to be interviewed. For instance, in one discussion a nurse told how the patient's mother sat on the edge of her chair, her hands clasped tightly, and stared ahead as if she were afraid to speak. The nurse said she had been utterly unsuccessful in trying to put the mother at her ease. This brought up the question of why the nurse needed to put the mother at ease, and the suggestion that the woman probably would have relaxed if the nurse had made her feel comfortable by the way in which she asked questions. The nurses usually need to be encouraged to feel that going further with a person into what they are trying to say is not "prying," but only helping the person express what the clinic needs to know.

The nurses feel more comfortable when they are in a home-visiting situation, familiar to them because of their past experiences as public-health nurses. In the home they feel more relaxed than they do in the more rigid office atmosphere. The nurses who are not overproductive in their office interviews blossom and expand when they go into the home, and they can tell a great deal about these visits in the group discussions.

Their impressions of the homes are revealing. What one nurse described as a "middle-class American home," turned out to be a home with substantial overstuffed furniture, a what-not filled with figurines, and a rigidly tidy atmosphere which, in itself, might have been formidable to the patient, who had grown up there. The nurses seem, for the first time, to see things that they had formerly only casually observed.

One nurse described a home as having a peculiar odor of dirt and an atmosphere of neglect. She tied this up with the schizophrenic personality of the mother herself, who was unable to be any more productive in the interview in the home than she had been in the office. This was the same woman who had sat tense and unrelaxed on the edge of her chair. In her home, the nurse could see how the mother, too, felt inadequate, particularly when she apologized for the furniture, which had been ripped from cover to cover by the

patient. The nurse said, "Had I not made that home visit, I would never have realized how sick the mother of the patient was, too." She was told that, although this mother had been known to many social agencies during the growing-up period of her children, the family had in no way been able to use the help offered by such agencies.

In this instance the nurse wanted to act as a reformer—"something should be done about this situation." Here she was taught what the clinic does and does not do; in other words, the function of social service in this setting. She read the records of the other agencies and saw what attempts had been made by them to work with the family, and where they had failed. Finally, she was able to suggest to the group that perhaps it was she who wanted to help the family rather than the family who wanted help for themselves. Such attitudes are common in persons who have not had social-work training.

The group's understanding of what goes into the diagnostic history comes about as a gradual process after much discussion of the meaning of the information for the psychiatrists, who would use it in furthering their understanding of the patient. Extraneous knowledge, such as regular feeding of infants, is apt to be recorded by the nurses because of their training from physicians and pediatricians. Only after explanation do they understand that the psychiatrist is interested in the unusual and bizarre—irregular feeding habits, difficulties in toilet training, illnesses that leave residuals or that carry high temperatures. These, they finally see, are more significant than the routine "measles at seven, chicken pox at eight, and pneumonia at nine."

The nurses at first have difficulty in being selective in their recording of facts. They must be taught to seek, in the interview, pertinent facts that show personality changes and indicate behavior different from the norm. They gradually emerge from the more rigid, formal type of history taking to a more flexible type of interviewing and recording, and learn to put together facts as significant as: "When patient was five, he began to run away from home when his mother gave attention to the newborn baby and ceased to spend as much time with him as she had before the baby came."

Every step of the way has been a question for these nurses. They have been uncomfortable in their new-found freedom. They are really taking their first steps at a more rapid pace than is given to social-work students in a first-year training course. This is possible because of their mature experiences. Their previous work with psychiatrists in other settings, and their own rigid background experience, both predispose them to be more ready than the student nurse for a sophisticated type of experience.

All through the program, the social-work supervisor keeps in mind the fact that what these nurses learn about social work must, of necessity, be telescoped when they go out to teach other nurses how to prepare social histories for clinics and hospitals. The most important thing for them to learn is what the psychiatric clinic should know about the patient's life history, prior to making a diagnosis. The nurses are told, over and over again, that the material they obtain is the "open Sesame" to the diagnosis, resulting in treatment or non-treatment, according to the psychiatrist's decision. This makes an impression, because the nurses realize how expensive psychiatric outpatient care is and how important it is that the few who receive it obtain as much benefit from it as possible.

In their cases the nurses have been concerned with a cross section of the diagnostic population entering an outpatient clinic, including neurotic as well as psychotic patients. However, they have not dealt directly with the patients themselves, as this area is left entirely to the psychiatrists. The nurses work with the interpersonal aspects of the patient's problem, while the psychiatrists become involved with the intrapersonal aspects.

When a patient is accepted for treatment, the nurse sometimes resents having to transfer her contacts, usually relatives, to the regular clinic or ward social worker. Thus, one nurse said, "Just when I am beginning to know Mrs. A., and she likes me, I have to leave her." This remark presented a good chance for a discussion of the function of the intake worker and how she prepares the patient for what the clinic is offering, but leaves him free to form another relationship with the psychiatric social worker after treatment begins.

The nurses bring to the whole experience much of their own feelings about human beings. The warm, friendly person who has had training as a nurse without becoming rigid can remain warm and friendly and still attain an understanding of her function. The nurse whose personality has been shaped by rigid routine, and who has difficulty in building up relationships and then releasing them, reflects these inflexible attitudes in her diagnostic histories. Thus, one nurse wrote: "Mr. F. is a typical bank clerk. You could not talk to him. He was dressed in his Sunday best and was very aloof." Since the record revealed her stereotyped feeling about bank clerks in the group discussion, she was helped to see the necessity of differentiating one bank clerk from another in order to relate an individual's problems specifically to his own life situation. However, she is still struggling with her own need to put people in pigeonholes.

The nurses are usually pleased when the cases they have prepared for the diagnostic clinic have been accepted by the psychiatrists for further care. On the other hand, they feel frustrated when patients already diagnosed as psychotic are sent back to their family doctor with recommendations for rehospitalization.

This experiment in interpreting one discipline to another is still in process of evolution. The plan for teaching those who have had long experience in the field of psychiatric nursing is certainly different from that required for teaching beginners in the nursing field.

While the method in this experiment seems sound, it might seem more relevant for interviewing to be taught by the schools of nursing as part of their basic curricula. However, since this is not being done at the present time, this system of affiliation seems a valid way to accomplish an important objective. Certainly, whatever is done to spread mental-hygiene concepts to the various professions represents a forward step.

COMMUNITY ORGANIZATION FOR MENTAL HEALTH *

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MENTAL health cannot be taken for granted. This is especially true in our present state of civilization, with its ever-increasing complexity, its rapid social changes, and the sharp focus of the diametrically opposed principles of the interdependence and the specific self-assertive aspirations of the members of society—that is, the coöperation and competition that make us friends and rivals at the same time. All these "are reflected in each individual as a personal conflict—one which he must settle for himself; and a successful solution in our present age is the exception rather than the rule."[1] Instead, therefore, of taking mental health for granted, we must fully plan and provide for it.

Although the problems of mental hygiene cannot be isolated into state or local patterns, we shall, for to-day, limit our discussion to the local or county organization. Sometime in the future we may have an opportunity to discuss the relationships of the local to the state organization and to the national bodies and the World Federation for Mental Health.

The tactics of organizing a community for mental health will vary from place to place, depending on a variety of factors, such as (1) what has already been done in this respect in the community; (2) the degree to which the leading individuals in the community are interested in and familiar with the techniques of mental hygiene; and (3) the most obvious needs and resources of the community regarding mental health. While the tactics of organization may vary, the goal in each instance is the same—*an adequate program for mental health.*

Awareness of the need for such a program undoubtedly

* Presented at the Session on Community Organization at the Fifty-fourth Annual Conference of the Illinois Welfare Association, Peoria, Illinois, October 31, 1949.

[1] See *Psychoanalytic Therapy*, by Franz Alexander and Thomas M. French. New York: The Ronald Press, 1946.

has existed in the local community for some time. Such awareness may have lurked—recognized or unrecognized—in the minds of many. It may have been present as a transitory, nebulous, uncrystallized feeling that "something is missing," or as a more permanent, well-recognized need. It existed in the mind of the teacher who was puzzled by Paul's inability to learn, despite his better-than-average I. Q.; of the parents who were anxious about Tom's bed-wetting and Mary's nail-biting; of the social worker who was concerned about Michael's stealing and truancy from home and school; of the physician with a young patient who required institutional care, but whose family could not afford to pay for private care and for whom care was not available in the state mental hospital. It existed in the minds of these and other individuals. They and others were aware of it because an inadequate program for mental health handicapped them in their work as parents, teachers, social workers, and doctors.

Why haven't they done something about it? Undoubtedly many factors operate to produce this situation. It has been suggested that training in these disciplines is not properly oriented to the community, with a resultant lack of interest in community problems; that preoccupation with individual treatment precludes real concern for community problems; and that professional people are almost inevitably overburdened in meeting the needs of the individuals in their care. These and other factors have been the obstacles that have prevented progress.

The first requirement for good planning, with its subsequent action, is that it be done by a number of people who get together and pool their ideas. The initiative in gathering together a group for informal discussions may be taken by any one—a government official, such as the county health officer, the county judge, the school principal, or the superintendent of the mental hospital; a private agency, such as the community chest or a family or child-welfare agency; or any citizen, lay or professional, who for some reason has an interest in the subject. It is wise to begin with a small group of persons—eight to twelve or fifteen, the natural size for effective human activity—who are already interested in such a program.

The sources that one may tap for such persons are varied. Doctors, social workers, teachers, judges, clergymen, nurses, and others may be interested because of their professional work. Members of civic and fraternal organizations and the press may be interested because of their concern with the welfare of the community. Others, because of personal experiences, may have a great interest in such a program. The state mental-hygiene society may be of some service to the local community even at this very early stage of organization. With members throughout the state, it may have on its rolls the very person or persons who would be of invaluable aid to the local group.

Consultation with the Illinois Society for Mental Hygiene would, therefore, be advantageous to a local group in Illinois. Such consultation does not in any way obligate the local group. In this matter, as in all subsequent relationships between the county organization and the state society, the latter will merely stand behind the local leadership in an advisory and consultative capacity and not in an hierarchical position. To do otherwise would be (1) poor mental hygiene, by fostering dependency rather than encouraging emotional maturation and the acceptance of responsibility, and (2) poor strategy by implying that the local leadership is not worthy.[1]

Sooner or later these informal discussions will make evident three important needs: (1) an educational program to disseminate widely knowledge of mental hygiene, of the anatomy and physiology of personality, and of emotional first aid; (2) a survey of community programs and facilities that will serve as the basis for future planning and action; and (3) a strong and enduring organization to carry out the educational and promotional activities.

These three needs are closely interwoven. The success or failure of any one is determined by the success or failure of either of the other two. A strong and enduring organization cannot be realized without the participation of a well-informed citizenry and a concrete knowledge of community needs, facilities, and gaps in program. Citizenship partici-

[1] See "Planning for Mental Health: Organization, Training, Propaganda," by George S. Stevenson, in the Proceedings of the International Conference on Mental Hygiene, London, 1948. New York: Columbia University Press, 1949. Vol. IV, pp. 248–50.

pation cannot be secured without capable leadership and an organization that will act as an integrating and coördinating body. Surveys, planning, and action are coöperative undertakings. They call for capable leadership, working hand in hand with an understanding public.

Where, then, do we start? Without attempting to answer the question of which came first—the chicken or the egg, it is apparent that an organization, while not as important as a program and while only a tool or a means to an end and not an end in itself, is an essential need.

The structure and form of the initial organization will vary greatly. In some instances, the informal discussion group can immediately constitute itself a provisional community mental-hygiene committee. In others, the mental-hygiene committee might well be one of the committees of the Community Chest organization or the council of social agencies. These provisional mental-hygiene committees may immediately proceed with the initial phases of defining the mental-health problems of the community and building up an educational program around these problems.

> "The preliminary educational program can profitably be organized by an educational subcommittee of the committee, working with the staff of the Illinois Society for Mental Hygiene. Within the local committee there doubtless will be found members able to present adequately to the rest of the committee an evaluation of at least some of the mental-health problems in the community as found in the sphere of activity of one vocation or another. For example, a school principal could tell something of the extent of mental retardation and the facilities for dealing with these problems in his school; a physican could tell something of the frequency of untreated neuroses in his practice or of child behavior problems if he be a pediatrician; a judge or a recreation worker could tell something of the incidence of delinquency and the facilities for handling predelinquent adolescents, etc. The staff of the Illinois Society for Mental Hygiene or other agencies outside of the community could help fill such gaps as the committee felt it needed in organizing and in carrying out the preliminary educational program."[1]

As the educational program develops, certain limitations, which impair the efficiency of the provisional mental-hygiene committee, will manifest themselves. Its membership, it will become apparent, is too small and not representative enough to cope with the many and diverse needs that have been

[1] See *Manual for Community Mental Hygiene Activities*, by Conrad Sommer. Chicago: Illinois Society for Mental Hygiene, 1939. p. 3.

unearthed. Its organizational structure, as a small discussion group or as a committee of a larger organization that has other and varied interests, may have a dampening effect on the realization of the program. Its lack of financial support or its financial dependence upon the parent body may act as a deterrent to its organizational, educational, and promotional activities.

ORGANIZATION

These are the indications for the establishment of a strong and enduring community mental-hygiene society whose one and only interest and whose very reason for existence is the promotion of mental health in the community. In planning for such an organization, the factors of structure, size, community representation, relationships to allied organizations in the community and to the state and national mental-hygiene groups, and other considerations must be kept in mind. Not all of these considerations are of equal or of immediate importance to the planning body.

From an organizational point of view, we must be guided by the principle that function determines structure. The functions of the local committee are sufficiently like those of the state society to warrant the patterning of the structure of the former after those of the latter. Those differences in function that do exist—such as the operation of a mental-hygiene clinic, which is a frequent responsibility of a local committee, but not a proper function of the state society—can, if necessary, be provided for by slight modifications of structure.

The constitution and by-laws of the Illinois Society for Mental Hygiene and its affiliates may be used by the local committees in organizing their societies. The Illinois Society for Mental Hygiene is prepared to assist local communities in the organization of their county mental-hygiene societies by making available to them (1) literature dealing with this subject; (2) the services of its staff members for consultation or speaking engagements at organizational meetings; and (3) the services of its speakers' bureau in arranging for speakers for organizational meetings.

The local leadership that is planning the organization of the county mental-hygiene society should, from the very

beginning, consider the question of affiliation with the state society. Such an affiliation would be mutually beneficial and would make more likely the realization of our common goal —an adequate program for mental health. Such an affiliation would make possible a coördinated attack on the problem of mental illness. It would obviate duplication of effort. It would permit a division of labor, one organization complementing the other. No state society can be really effective unless it has strong local groups. The state society, however, is neither a parasite nor a vampire. While it draws its strength from the local society, it also gives strength to the local society. No local society can be strong, effective, or enduring unless it avails itself of the services and assistance that only a strong state society can offer. "In an era in which welfare, educational, and mental-health services are increasingly arranged on a state-wide basis it is expedient to have this kind of collaboration between state and community mental hygiene societies."[1]

The local society, an organization "of the people, by the people, and for the people," affords us the means of achieving a real grass-roots movement. The failure of the mental-hygiene movement to realize its goals stems primarily from the fact that local societies, as envisioned in this paper, are as yet largely undeveloped. Effective local societies can sustain and feed the movement toward world mental health by:

1. *Enlisting new members.* Members are the life blood of any organization. Dr. George S. Stevenson has said that a reasonable goal toward which we should aim is one member for every psychotic person.

2. *Recruiting and utilizing volunteers.* The mental-health field requires the services of all the people—skilled or unskilled—serving in a professional or a volunteer capacity. The recruitment and development of volunteers is the responsibility of the local society.

3. *Carrying on a direct educational program.* This will be discussed later in the paper.

4. *Introducing mental-hygiene concepts into local social institutions,* such as, the schools, churches, courts, protective child-care institutions, industry, and so forth.

[1] Sommer, *op. cit.*, p. 7.

5. *Surveying local mental-health facilities and programs.*

6. *Supplying direct services,* as by the operation of a mental-hygiene clinic.

While it is not the purpose of this paper to discuss the functions and responsibilities of the state mental-hygiene society, a few examples of these will serve to illustrate how its functions aid, complement, and supplement the work of the county society. The state society:

1. Acts as a clearing house on all matters pertaining to mental health. This service may be of great value to the local community organization in its educational and promotional activities.

2. Acts, unofficially, in a consultative capacity to the public agencies concerned with psychiatric programs and facilities. Thus the state society is in a position to advise and assist the local community organization in its mental-hygiene surveys and mental-health planning.

3. Concerns itself with legislative measures that affect people throughout the state.

4. Prepares and carries out educational and professional programs that are readily applicable, *in toto* or in modified form, in local communities throughout the state.

5. Prepares or purchases educational media—books, pamphlets, exhibits, films, and so on—which are available to local community organizations.

6. Maintains a staff upon which the local community organization may call. The staff may be numerically inadequate, but it will increase as the number and strength of the county mental-hygiene societies increases.

EDUCATION

Mental-health education is an end in itself as well as a means to an end. It is an end in itself in that it gives us all the opportunity of attaining a basic understanding of mental hygiene and some working knowledge of emotional first aid. "While it is obvious that mental-health education is by no means a substitute for psychiatric treatment, it is, by far, the most effective tool we have in promoting positive mental health."[1] Mental-health education is a means to an end in

[1] See *Program Guide for Local Mental Hygiene Associations,* by Marian McBee. New York: New York Committee on Mental Hygiene, 1948. p. 1.

that it (1) arouses community-wide interest in mental health; (2) sheds light on community mental-health needs; and (3) gains support for administrative and legislative programs that will correct existing deficiencies.

Who should be taught? Self-education comes first. This has already been discussed. Self-education should be followed by community-wide education. Community-wide education should include all those who influence the mental health of others. This includes all of us. In our daily relationships as parents, teachers, employers, employees, shop foremen or stewards, judges, policemen, probation officers, and so on, we influence the mental health of those about us and should, therefore, be included in such an educational program.

Parents, for example, who have the responsibility for raising their children to be mentally healthy adults, must have at least a minimal knowledge of the all-important job of being a parent. Teachers, the first important parent substitute the child encounters, have a tremendous influence on the mental health of the child and hence should have an understanding of mental-hygiene principles and techniques. Police officers, who almost daily come into initial contact with all kinds of relational disturbances—family quarrels, attempted suicides, alcoholics, and psychotics—should have an understanding of the science of human relations. It is apparent that everybody could benefit from a mental-health educational program.

The educational program may be directed along two main channels: (1) specialized programs for vocational groups, such as nurses, teachers, ministers, and so on; and (2) general programs for all members of the community. In the latter instance, the specialized interests of the group must, as far as possible, serve as the starting point. Thus special programs might well be planned for such groups as prospective mothers and fathers who want to get off to a good start with their growing families; cautious parents whose children do not present problems and who want to go on avoiding problems; friends and relatives of individuals under the care of a psychiatrist or in a mental hospital who are concerned about what is going on within the psychiatrist's office or in the hospital; and many other groups with similar interests.

What should be taught? No general formula is applicable

to each and every community or for each and every group. Each program must be individually tailored to meet the individual needs of the situation. In general, it may be said that the educational program should answer such questions as: What is mental hygiene? What are the present-day concepts of mental hygiene? What factors in the environment, internal and external, contribute or are detrimental to mental health? What are the mental-health needs of the community? What are the legal provisions relative to the certification and custody of the mentally ill, the mentally defective, the psychopaths, and the "sexual psychopaths." What facilities are there available in the community? Are these facilities adequate?

The educational program must be couched in positive terms. It must go beyond the problem of the acutely ill to the matter of the mental health of all members of the community. It must take into consideration the four separate and distinct objectives of mental hygiene: "(1) that the mentally ill should receive humane care in keeping with the standards of the population; (2) that the mentally ill should have the benefit of scientific treatment; (3) that the factors which contribute to the production of mental illness should be reduced or eliminated as far as possible; and (4) that the mental health of the population should be maintained at the highest possible level."[1] Briefly, the educational program, as well as planning for mental health, must take into consideration care, treatment, prevention, and positive mental health.

The phrase "positive mental health," for lack of a better term, is used in the hope that it will serve to clarify the present confusion as to what constitutes preventive service. It is the commonly accepted opinion that early treatment, as in child-guidance centers or outpatient clinics, is prevention, the argument being that early treatment may prevent a more chronic or serious emotional disorder. To that extent, the services offered by such facilities are preventive. We must not, however, lose sight of the fact that the presence of the individual in such a facility, and his acceptance by the facility as a patient, is in and of itself an indication of the presence of some emotional disturbance—mild, perhaps, but an emotional disturbance nevertheless. "Positive mental health has

[1] Stevenson, *loc. cit.*, p. 222.

to do with well persons. It has to do with the enhancement of the capacities of well people to live productive and satisfying lives. Such living is dependent upon the extent to which one's potentialities are given a full opportunity to develop and function."[1] Thus programs for positive mental health are oriented toward increasing the individual's ability to adjust to external and internal stress and to aid him in maintaining mental health as the key to effective personal and social living in a democratic society.

How should it be taught? Educational techniques vary. They vary with the personality of the educator and the persons being educated. Lectures, lecture courses, discussion groups, residential courses, and case-work demonstrations, or various combinations of these have been used. The educational media range from one- or two-page pamphlets to magazines, books, and audio-visual aids, including films, radio, and recordings. The comparative efficacy of the many methods and media has not yet been determined. A great deal of research is needed in this field. For the present, the educator will have to exercise considerable initiative and ingenuity to satisfy the many and diverse requests for educational programs.

PROMOTION

The promotion of mental-hygiene services is a natural outgrowth of mental-health education. Mental-health surveys, which must precede promotional undertakings, are difficult tasks. Facilities and programs should not be sponsored only because of a local or an immediate need. The long-term value of such projects and their relationship to the state-wide program should be carefully considered. Expert help and guidance and knowledge of the entire field are essential. Certain publications—such as the *Outline For Evaluation Of a Community Program In Mental Hygiene,* by the Group for the Advancement of Psychiatry;[2] the *National Mental Hygiene Program,* by the National Council of Jewish Women;[3] and *The National Mental Health Act and Your Community,* by the Federal Security Agency[4]—are important

[1] *Ibid.*, p. 225.
[2] Report No. 8, April, 1949.
[3] June, 1949.
[4] Mental Health Series No. 3, June, 1948.

as guides to the type of thinking and planning necessary to an effort to raise the level of mental health in the community. The excellence and availability of these reports, particularly the one by the Group for the Advancement of Psychiatry, obviates the necessity for a repetition of their contents at this time. Study these reports. Apply them to your own community.

The following brief outline of programs and facilities and agencies interested in the field of mental health in Illinois will give you a clue as to what to look for and what you may find in your own community.

OFFICIAL AGENCIES

At the State Level:

The Illinois Department of Public Welfare has been charged, since 1917, with the responsibility for the care and treatment of the mentally ill in Illinois. By itself, or in coöperation with other agencies, it operates nine mental hospitals; two schools for mental deficients; two correctional institutions; a facility for the criminally insane (Chester); the Institute for Juvenile Research, with its downstate clinics and its 14-bed inpatient facility; and approximately forty community clinics scattered throughout the state. In addition to these existing facilities, the welfare department has been authorized, by the 65th General Assembly, to establish a research institution (at Galesburg) for a study of the problems of mental health in the aged and the erection of another mental hospital. There are also plans for the establishment of an inpatient facility for the seriously emotionally disturbed child.

The program of the welfare department is all-inclusive. It concerns itself with the young and the aged; the mentally ill and the mentally deficient; the delinquent and the criminally insane. It has responsibility for custodial care, active treatment, preventive services, and educational programs for professional and lay groups.

The Illinois Department of Public Health was, in 1947, designated as the state mental-health authority. As such, it is responsible for "establishing and maintaining adequate public health services . . . [providing] demonstrations . . . [and] training of personnel for state and local health work."[1]

[1] See the National Mental Health Act, Public Law 487, 79th Congress.

Under this authority the state health department has made funds available for the expansion of existing and the development of new mental-hygiene clinics and the training of professional personnel, and it has sponsored various educational programs for lay and professional groups.

The Illinois Department of Public Safety cares for the criminally insane at Menard.

At County and City Levels:

Time will not permit a discussion or even an outline of the mental-health work of the various local communities. The public facilities of Cook County and Chicago will serve to illustrate the many agencies concerned with mental health.

The Cook County Psychopathic Hospital serves as a clearing house to the state mental hospitals for psychiatric patients in the Chicago area. The hospital is shared as a teaching clinic by the medical schools in Chicago.

The Psychiatric Institute of the Juvenile Court and *the Behavior Clinic* serve the juvenile and the criminal courts, respectively.

The Cook County Health Department has recently entered the field. With funds made available to it under the National Mental Health Act, it has provided postgraduate training in psychiatry and mental hygiene for two of its nurses. It is now organizing a training program for personnel within the county health department.

The Mental Hygiene Section of the Chicago Health Department was established in 1947. The functions of this section are stated as follows:

> "1. The primary function of the division of mental health should be the orientation of the board of health staff in the field of mental health through a continuing in-service training program, particular emphasis being given to the prenatal, infant welfare, pre-school, school health, and venereal disease programs.
>
> "2. In so far as funds permit, the Chicago Board of Health should consider making funds available for expansion of community clinical facilities for psychiatric outpatient care."[1]

The Psychiatric Institute of the Municipal Court of Chicago was established in 1914. Its services to the municipal courts of the city are "purely those of diagnosis with submission of

[1] Summary of the meetings of the Advisory Committee on Mental Hygiene to the Chicago Health Department, February 16, 1948.

recommendations to the court and/or referral of the patients for hospitalization or outpatient treatment."[1]

The Bureau of Child Study, Board of Education, City of Chicago, "is an integral part of the City of Chicago school system. Its program consists of a coöperative service between the schools and itself, chiefly through the medium of the adjustment teacher . . . [whose duties] are directed to aid in the solution of the problems of the children . . . There are three special schools caring for children with the more serious behavior problems in the school system."[2]

NON-OFFICIAL AGENCIES

In addition to the official agencies, there are many non-official agencies which concern themselves, to a greater or lesser degree and in a variety of ways, with the problems of mental health. The facilities and energies of professional agencies, such as medical schools, hospitals, clinics, and sanitaria, are directed primarily to teaching and research purposes. Individuals in the professional disciplines in these organizations, including, as they do, many dynamic personalities, frequently accept the leadership, or play an active rôle, in the promotion and maintenance of mental health in the community.

Ordinarily, it is not the policy of these agencies, as agencies, to bring their influence to bear in the development of mental health in the community or to relate themselves to such broad community responsibilities. Other professional groups, however—such as the Illinois Psychiatric Society, the Institute of Medicine of Chicago, the Illinois Association for Applied Psychology, and the American Association of Psychiatric Social Workers—have used their influence and the prestige of their organizations to promote a more wholesome and intelligent attitude of the community toward the problems of mental health and to help find more adequate means of dealing with the problem.

Semi-professional and lay groups have contributed and are

[1] This quotation appears in the unpublished report of the Chicago-Cook County Health Survey, Mental Health Section (p. 39). It does not, however, appear in the exact form given here in the published report of the survey (New York: Columbia University Press, 1949).

[2] *Ibid,* p. 42.

continuing to contribute much in this field. In the American Red Cross, "we have an organized, already interested group of people who can be brought to participate in the work of the [mental] hospitals. Such participation ranges from help in the circulating libraries and the recreational departments, to instruction of patients in the handicrafts employed in occupational therapy."[1]

The National Council of Jewish Women "has developed an intensive program of self-education for its members through study courses given by local authorities in the field." To follow this orientation, the council suggests to its sections, as activities, "the sponsorship of community-wide forums within the framework of education, prevention, and legislation. Such forums . . . are a first step in promoting community wide interest in the setting up of a mental hygiene society."[2]

WHY A MENTAL-HYGIENE SOCIETY?

It is apparent that mental health is everybody's business. Official and non-official agencies, lay and professional groups have interested themselves in this field. As a well-known comedian has frequently repeated, "Everybody wants to get into the act." Such apparently widespread interest is a healthy sign, but it is not an unmixed blessing. It poses many problems. It contributes to duplication of effort and expenditures; departmentalized thinking, planning, and action; poor utilization of sorely needed, scarce personnel; petty rivalries, with the prestige of the particular agency or group too often taking precedence over the mental-health needs of the community; and gaps in service, which may go unrecognized or, if recognized, may not be accepted by any existing organization as their responsibility. Thus a new group is organized to meet the need. The already existing confusion is compounded. Every one goes merrily on his way. Few know what others are doing or trying to do. Some are not even fully cognizant of what it is that they themselves are doing. No one knows what the over-all picture is or what the over-all needs are.

[1] "Opening the Doors of the Mental Hospital to the Public," by Newton Bigelow. MENTAL HYGIENE, Vol. 33, July, 1949. p. 369.

[2] National Council of Jewish Women, *op. cit.*

The United States Public Health Service took cognizance of this situation in its report on the Chicago-Cook County Health Survey. It said:

> "This review of psychiatric facilities and services in the Chicago-Cook County area reveals a surprisingly large number of agencies (tax-supported and voluntary) engaged in the provision of various types of psychiatric care. Sponsorship of these services by so many and such diverse groups indicates a general awareness of the need for psychiatric service, but the lack of coördination of the various activities hampers the effectiveness of their work. While the survey has revealed many shortcomings and deficiencies, some of which, such as the shortage of professional personnel and the inadequacies of financial support, reflect nation-wide conditions, establishment of an over-all organization to coördinate the present independent psychiatric activities is perhaps the first step which should be taken by the Council of Social Agencies of Chicago and the other organizations and agencies sponsoring psychiatric services."[1]

Its first recommendation was that:

> "An organization shall be established to integrate all the inpatient and the outpatient psychiatric services in the Chicago-Cook County area, including psychiatric social service. This organization should coördinate the activities of tax-supported and voluntary institutions and agencies, including the proprietary institutions. The Illinois Society for Mental Hygiene might serve as such a coördinating body if the interested groups wished it to perform that function and if its services were strengthened and expanded. Otherwise, a new agency might be set up."[2]

A mental-hygiene society, with no vested interests, utilizing the interests and skills of professional and non-professional persons, offers a unique vehicle through which the responsibilities of all people for improvement of community mental health may be discharged.

In addition to such a contribution to the community, the mental-hygiene society is in a position to make a contribution to the mental health of the individuals who participate actively in its program. It is a well-established fact "that the healthiest forms of social organizations are those which provide for their members the greatest scope for participation and spontaneous activity."[3] Our government—national, state, and even local—has become so far removed from the

[1] *The Chicago-Cook County Health Survey*, conducted by the United States Public Health Service. New York: The Columbia University Press, 1949. p. 596.

[2] *Ibid*, p. 602.

[3] See "Planning for Mental Health: Organization, Training, Propaganda," by Ferguson T. Rodger, in the Proceedings of the International Conference on Mental Hygiene, London, 1948. New York: The Columbia University Press, 1949. Vol. IV, p. 215.

ordinary life of the ordinary citizen that it is difficult for every individual to play his part. This is not so with a well-organized mental-hygiene society.

An effective mental-hygiene society "contributes to the mental health of a community not only by propaganda and instruction, but also by the example it gives of healthy, purposive activity."[1] By participation in such an organization, "the ordinary citizen can again feel that he is a real participant and has a direct responsibility for the handling of the affairs of his neighborhood."[2] This would be a mental-health gain for the individual. It would be a realization that it is not "They"—in Washington or Springfield—who make the laws and decide what will happen; or "You" who must do this and assume the responsibility if success be not attained; but that "it is 'We' who get things done. . . 'You' cannot do much. 'They' won't do much. 'We,' together, can do the work and take the responsibity. Not we alone—but we, gathering strength from all who will join us in a great conviction—but always WE."[3]

[1] *Ibid.*

[2] *Ibid*, p. 216.

[3] See "The People's Program," by Alan Gregg. MENTAL HYGIENE, Vol. 32, January, 1948. pp. 2–3.

THE RÔLE OF A PSYCHOLOGIST IN A TRAVELING PSYCHIATRIC CLINIC

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THE national mental-health problem is a tremendous one. Emotional disorders are ubiquitous. While larger urban areas are likely to have some psychiatric facilities, these services are usually completely absent in smaller towns and rural areas.

Traveling psychiatric clinics evolved as an answer to this problem. Although originally stimulated by the lack of local residential clinics, subsequent experience has indicated that the traveling clinic is not a temporary substitute for permanent clinics, but will always be needed in areas that cannot support—and, indeed, do not need—full-time psychiatric facilities.

What is a traveling psychiatric clinic? At the present time in Colorado this type of clinic is composed of a visiting psychiatrist and psychologist from the Mental Hygiene Division of the Department of Psychiatry of the University of Colorado Medical Center plus the local child-welfare worker. The psychiatrist and psychologist visit the community for periods of one or two days at regular intervals, varying from once a week to once a month, the frequency of the visits depending upon such factors as need, readiness, and distance.

The functions of the traveling clinic and its personnel are dependent upon (1) the particular needs of the community—*i.e.*, of the courts, schools, and so on; (2) existing local facilities, such as other organized social agencies, and their awareness and willingness to participate in the local mental-health program; and (3) the frequency of the clinic visits.

The present Colorado clinics are set up so that all cases in which the emotional component is thought to be important can be referred by any agency or individual in the community—by schools, social workers, nurses, doctors, judges, sheriffs, lawyers, clergy, or families; or the individual may come on his own initiative. Evaluations are requested for patients of

every conceivable age, ranging from infants three and four months old to very elderly persons. Not only cases of "pure" emotional disturbances are referred, but emotional problems arising from all types of organic disability, such as cerebral palsy, blindness, deafness, orthopedic handicaps, and neurological and endocrine disorders.

Community agencies are entirely dependent upon the traveling clinic for psychiatric evaluation of these patients. The rôle of the clinic, therefore, becomes one of helping them to define the problem that the patient actually presents and their function in relation to it. The latter is very important. Each community has its own resources—meager as these may sometimes be—which should be utilized. With help and support from the clinic, these resources for mental health can be more fully recognized, developed, and employed.

The clinic does not set itself up as a place where directive advice on the handling of patients is freely handed out. First of all, diagnosis from a brief contact is not always possible. Secondly, transient clinic personnel cannot possibly know local facilities intimately enough to make appropriate direct suggestions to them. Finally, it is not the rôle of the clinic to act in an administrative capacity. For example, a school refers an eight-year-old boy who is not learning well. We discover, among other things, that he has a mental age of five years. In discussing him with his teacher, we can talk with her about his level of functioning, his home problems, and so on. If she asks us whether he should be placed in another grade, we really cannot make the decision for the school. We do not know the situation well enough—*i.e.*, the make-up of the classes, the other teachers' interests in this boy, and so on—and it is not our function to tell the school how to operate. Our responsibility is to discuss our evaluation of the child with the school and to help them define their function in relation to him. What they receive from the clinic is then utilized within the range of the available facilities and of their capacities to help this particular patient.

Because the clinic personnel functions as a team, adequate description of the rôle of the psychologist necessitates a brief orientation as to the function of the other members of the clinic team and of the clinic itself.

The social worker is usually the local child-welfare worker, who has been trained to identify and work in areas of emotional disturbance on a case-work level. That it is necessary for the social worker to reside in the community is implied in her position of liaison between the traveling members of the clinic and the community. That is, she acts as intake worker, evaluates all cases referred to the clinic from the point of view of their need for psychiatric investigation, prepares patients for clinic service, and frequently, on a case-work basis, implements the findings of the clinic with follow-up care.

The psychiatrist, utilizing all the information obtained by the psychologist and the social worker—from interviews with the patient, his family, and other interested persons—clarifies the problem through a discussion process, and helps those present at the case conference to determine how the patient can best be helped.

All cases are handled by the social worker. For example, a probation officer, wanting help with an adolescent boy who repeatedly runs away from home, gets into touch with the social worker and presents the problem to her for consideration. She evaluates the problem to see whether it can be helped in view of the reality factors involved. If, after careful investigation, she feels that the case will benefit from clinic attendance, knowledge of the clinic facilities is then made available to the child's family. If the family wishes to avail itself of the clinic services, an appointment for the next clinic is arranged. From her contacts with the patient, the family, the school, and other interested agencies, a social history is prepared for presentation to the visiting-clinic team, thereby making available as much pertinent information as possible about the total situation.

On the appointed day, one or both parents and the child come at a designated hour. The usual routine is for the psychiatrist to see the parents first, each alone, while the psychologist sees the child. The psychologist evalutes the type of psychological study needed from the history, the reference notes, and consultation with the psychiatrist. He administers tests and makes special observations that will help in evaluating the child. When his study is completed, he discusses his findings and impressions with the psychiatrist.

Throughout the day a number of conferences are scheduled. The child-welfare worker, the psychiatrist, and the psychologist, plus representatives from whatever agencies are most concerned, sit in on these meetings. There is a mutual exchange of information and opinion. At all times the focus is on allowing local persons to "talk out" some of their feelings about the patient, to help them gain some understanding of the possible dynamics of behavior the child is showing, and to discover ways of utilizing existing local facilities to help him.

Thus we see the clinic as oriented toward helping local workers to understand the problems that their patients present, and determining how best these problems can be managed by them within the community. If the problem calls for utilizing resources outside the community, the clinic rôle is still one of helping the local people understand their own responsibilities in relation to the problem.

The diagnostic activity of the clinic team includes determining how extensively disturbed a patient may be—that is, whether he is psychotic, neurotic, or normal. Consideration is then given to his personality structure and capacity for adjustment. These two main areas of functioning require an evaluation of inherent intellectual capacities; of the presence, degree, and type of emotional deviation; and of the etiology of these deviations—that is, whether the causal factors are organic or psychogenic and the degree of relationship between these factors.

Because of the brief time available for each patient, incisive and decisive techniques which can aid in rapidly revealing personality structure and dynamic etiological factors are of paramount importance. This determines the psychologist's primary function in a traveling clinic—*i.e.*, that of assisting in a diagnostic evaluation of the presenting problem. The psychologist can contribute much to differential diagnosis on a short-term basis. Many psychological testing techniques are well suited to the relatively rapid establishment of a differential diagnosis which cannot always be made in a brief clinical interview by the psychiatrist, but which, in a permanent clinic, would be ascertained over a longer period of time through extended contact with the patient.

We see this illustrated in other branches of medicine. For

example, the general practitioner, over a relatively long period of time, can come to know a patient intimately and arrive at a differential diagnosis without the aid of laboratory investigation, but if he were limited to a few hours, it would be necessary for him to avail himself of a battery of investigative laboratory procedures, such as X-ray, urinalysis, blood count, and so on. The same problem is encountered in the traveling clinic. The psychologist can, within a relatively short period of time, uncover considerable diagnostic material.

For example, a woman recently referred to the clinic was considered feebleminded by local police and welfare workers. A fire in her home had burned two of her children to death. She had made no effort to save the children and had been found by neighbors indifferently watching the fire. She showed no concern over the loss of the children and never visited a third child, who was hospitalized for severe burns. The community was disturbed over her seeming lack of feelings. The patient, a woman twenty-three years old, was very disheveled and listless. The Wechsler-Bellevue full-scale score was 96. A Rorschach revealed a schizophrenic personality structure, although clinically the woman had given the impression of mental retardation. It was then possible to discuss the patient's illness with the welfare worker, not in terms of mental dullness, but of mental illness and the patient's obvious need for hospitalization.

A nine-and-a-half-year-old girl was referred by her teacher because her school work was poor and she seemed to be "a strange child." The child's mother felt that the girl had a "block" that kept her from learning. She revealed that she had always been embarrassed by the child's queer ways and unpredictable behavior, and dreaded going anywhere with her. The patient was a tall, awkward, hyperactive child whose speech was halting and slow. She achieved an I.Q. of 97 on Form L of the Stanford-Binet scale. Other tests revealed a marked lack of visual-motor coördination, a tendency to perseveration, and poor motor skills. An electroencephalogram and neurological examination revealed diffuse cortical pathology. At an ensuing clinic, the function of the psychiatrist was to interpret the situation to the mother while the psychologist discussed the situation with the teacher. Subse-

quently, the mother has been seen on a weekly basis by the child-welfare worker to assist her in working through some of her disturbed feelings about the child's organic difficulty.

In addition to differential-diagnostic problems, the psychologist assists in general evaluative procedures of help to workers. Many infants who are to be placed for adoption are referred by the state child-welfare department. The psychiatrist and psychologist see the child together and evaluate in so far as possible the level of development. The social worker, with whom these findings are discussed, advises the state child-welfare-department placement board as to the suitability of the infant for adoption. The main purpose is to prevent the adoption of obviously defective children. Frequently very retarded babies have been designated as "normal, healthy infants" by local medical agencies solely on the basis of negative Wassermanns and a lack of gross physical abnormalities.

For example, a girl fifteen months of age, who every one would agree was a "healthy baby," was referred. Physical examination had been essentially negative. However, she was unable to sit up alone; when placed prone on the table, she made no downward pushing or adequate postural adjustments. The child's gross retardation was discussed with the worker, who then made plans to keep the child in a boarding home rather than place her with adoptive parents.

Also, the worker may want to know if a child appears to be getting enough mothering care in a boarding home. Often we see young infants who are flat, apathetic, and unresponsive at four to six months of age, evidencing inadequate care. If this appears to be the case, the worker will want to find another boarding home, where the baby can receive more adequate mothering prior to being placed with permanent adoptive parents.

In rural areas the psychologist is regularly called upon to assist in evaluating emotional and intellectual factors in blind, deaf, and brain-injured children who are referred by home teachers, doctors, crippled children's clinics, speech teachers, occupational therapists, and physiotherapists. Not only must the psychologist be able to evaluate these children, but he must also be very familiar with state and local facilities

for their training, so that he can participate in discussions for referring such cases to appropriate training facilities or aid in outlining possible treatment in the community. A very necessary requirement is familiarity with the special educational methods used with these patients. The psychologist is not expected to function as an expert consultant on specific techniques of training, but he should be able to offer consultative help on the child's response to the training methods.

Another function of the psychologist is to participate in community-educational projects. He is called upon to give talks before lay groups and to assist in mental-health orientation for public-health nurses and welfare-department staffs.

One very interesting participation project has been going on in Pueblo. Each month for the past three years one of the grade schools has asked the clinic team to present a case discussion at the teacher's meeting. The social worker has helped the school select the cases that they desire to have presented, so that common classroom problems will be investigated. The school has referred stutterers, withdrawn or aggressive children, feminine boys, slow-learning or brilliant students, daydreamers, enuretics, and a variety of other common problems. We use the child they refer as a basis for discussion of the general problem he presents. The social worker discusses her contacts with the home. The psychologist reviews the results of the thematic-apperception test, the Rorschach, and other procedures that he has used with the child. We show some of the thematic-apperception-test cards and the stories the children gave, relating the content and interpretations in everyday terms.

It is amazing how much acceptance and understanding the teachers show of projective and psychometric techniques when they are presented in this way. They easily pick up and relate the content of children's drawings and fantasy stories to the conflicts the child has, and begin to sense that all behavior has meaning. While their ideas tend to be very superficial, we have noted during this period that many teachers in the group have changed their attitudes toward disturbed pupils. Our main goal has been to make it clear that behavior has a purpose. For example, a teacher relates that a child is said to "mind beautifully" at home, yet in school is a severe

behavior problem. We may relate the defiance in school to his basic conflicts with his mother at home. If nothing else, the teachers have in general become very much interested in the out-of-school lives of their pupils and very conscious of how these activities affect behavior in class.

In order that the psychologist may participate effectively in such a program of community consultation services, he must be clearly aware of the function of each worker in the various community organizations and able to present his findings in the most meaningful and usable way. For example, he must know the social worker's approach to case-work with a client, the relationship between a physiotherapist and his patient, and the manner in which a visiting nurse works with a family, so that he can discuss in meaningful terms what it is important for each to know in his or her contacts with the patient.

For example, an immature, impulsive young housewife slashed her wrists in an abortive suicide attempt in the face of excessive financial and family stresses. The clinic was asked to discuss their impressions of the patient with her family doctor, a public-health nurse, and a worker from the department of public welfare. The psychologist had administered a Rorschach test. The findings had to be given in terms of the rôle that each of these persons would have with the patient—*i.e.*, they had to be explained in valid yet simple and concrete terms that would be meaningful and usable to each at the different levels at which they would establish a relationship with the patient.

Now that we have discussed the functioning of the traveling clinic, the rôle of the psychologist in it, and the community service it offers, it is logical to ask how successfully this program meets community needs.

Since 1925, traveling units from the Colorado Medical Center have been active throughout the state. Many communities, including Greeley, Pueblo, La Junta, Glenwood Springs, Grand Junction, Boulder, Alamosa, Durango, Sterling, and Fort Collins, have had traveling clinics. These areas were visited only when full-time child-welfare workers were present in the community to implement the clinic services. During the period from 1925 to 1946, 3,787 individuals were examined. However, in the last two and one-half years over

800 patients have been seen in these clinics. This expansion is due to an increase in clinic personnel and to greater community interest in the utilization of these clinic facilities.

An analysis of the handling of cases in community clinics during the last two and one-half years reveals that 21 per cent of the cases were treated by the psychiatrist; 21 per cent were treated by the social worker under the supervision of the psychiatrist; 53 per cent were seen for diagnostic interviews followed by consultation with agencies and parents; 5 per cent were case presentations in which workers discussed problems in handling clients who were not seen in the clinic. Thus we see that approximately 80 per cent of the cases were cared for in the community by local personnel.

A thesis at the University of Denver School of Social Work brought out the effect of community participation. One hundred and fifty-five cases treated in community clinics from 1936 to 1944, in which records were complete enough to show the process and results of treatment, were selected. A large number of these follow-up cases showed that treatment had resulted in sustained benefit. In reviewing some of these cases, it was thought that the results could be attributed to the effect on the community and on parent-child relationships of the long-sustained clinic program.

IS YOUR CHILD WELL-BRED?

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ONE of the most scathing criticisms that can be leveled against our children and our young people is that many of them seem crude, crass, and lacking in the most common courtesy or respect for adults, for parents, for one another, and even for themselves. Time and again, we hear of instances of lecturers or artists who have appeared before groups of young people—in school assemblies, for example—and have found the audience behavior of these youngsters so impossible that the program had to be discontinued or at least interrupted by some one in authority in order to restore something resembling order. What parent of teen-age youngsters has not blanched to hear the neighborhood gossip or even read the morning-newspaper accounts of the riots or near-riot behavior of his children's friends and classmates after athletic events or out-of-town school expeditions and field trips—realizing that but for some lucky accident, his own child might have been involved?

Most of us, too, have been surprised to see the careless impoliteness and lack of ordinary courtesy that many grade-school youngsters extend to adult school visitors, or we have seen their almost vulgar behavior on their way to and from school toward the people they meet, both pedestrians and auto drivers alike.

Those of us who have worked with these children, however, who know them intimately in their day-to-day activities, and who have come to understand something of their difficulties in achieving maturity, have faith in their fundamental wholesomeness. We believe that in spite of their sometimes crude, unthinking behavior, they earnestly want to learn to be acceptable to the world, both now as children and as future

adults in the "grown-up" culture in which they soon must take their place. Because it is only through sympathetic understanding that we can help them to overcome these socially immature ways of acting, many of us are interested in finding out why it is that we have such undesirable behavior in these ordinarily pleasant and good-natured youngsters, who in some ways are so alert to the fine, intangible aspects of personal relationships and so eagerly responsive to most social pressures.

It is perhaps possible, to be sure, that in our democratic attempt to give our young people a greater degree of freedom in controlling their own behavior, we have necessarily lost a certain amount of courteous and respectful behavior which, although it made the child of a generation ago more inhibited and to some extent limited his initiative, also, nevertheless, made him a somewhat more agreeable person with whom to live and associate.

We believe firmly, however, that liberty does not necessarily mean license, and that it is entirely possible for a child to retain his spontaneous joy in life and in activity and still to develop the ability for self-direction without making himself socially obnoxious. How, then, can we permit our children this essential freedom and at the same time help them to be and to remain pleasant and considerate companions?

Much of the control that society exercises over the behavior of its individual members has always stemmed, of course, from the deeply ingrained codes of "taken-for-granted" axioms regarding personal relationships that form an essential basis for the group activity of all of the small, intimate personal *groups* of which our social order is composed. Codes of behavior also develop around the *places* in which specialized activity occurs, different forms of behavior being automatically assumed, for example, upon entering a church, a baseball diamond, a night club, or a hospital.

The youngster of to-day, however, is growing up with considerably less both of this "place-consciousness" and of this long-standing familiarity with well-defined group codes, largely because of the diversity of our activities in modern life and because of our greater mobility of living. The young

man or woman or even the little child of the present decade not only is permitted, but is expected as a matter of course to be able to enter into, and to deal effectively with, a broader variety of life situations than was considered even suitable for his grandparent.

A respectable young woman of the upper middle classes, for example, used to be admired if she could carry on successful activities within the sphere of "*Kinder, Küche, und Kirche,*" and she was rather expected to limit herself to these fields. To-day's adolescent girl or young matron, however, is expected to direct her own behavior not only in these areas—important as they still are—but also on the bathing beach and the golf course, in the industrial plant, in a broad variety of school, business, and social and welfare work situations, and in many more besides.

Because our population has become so startlingly mobile in the matter of its dwelling places, as well as so versatile in its day-to-day activities, the young person of to-day has also lost thereby much of his feeling of *group loyalty* which served to stabilize earlier generations by supplying them not only with ready-made codes of behavior for various times and places, but also with an interested group of intimate associates who were concerned about the actions of the individual group member *and* who were directly and deeply affected by what each group member did.

To-day our young people live for a short time in one neighborhood or school district or city, and then move on for a few months or years into another part of the country, perhaps never returning to their earlier home and community for even a casual visit. In many cases the young person of our modern culture fails to establish firm group loyalties to any group—school, work, social, or religious—with which he is for a time affiliated. Little wonder is it, therefore, that he fails to see his own behavior as even related to the welfare of the group with which he is for the time being associated—much less as reflecting upon it or as morally subject to its control.

The "turnover" in registration in some of our city elementary schools, for example, is sometimes as high as 30 per cent; that is, in the course of each year approximately

one-third of the children transfer from one school to another, either within the same city system or from one system to another—involving for each child, of course, an accompanying transfer from one informal neighborhood play group to another, as well.

Many first- and second-grade children have thus already attended two or even three or four different schools. And these are *not* the children of itinerant workers; these are the children of the ordinary "stable" citizens of our culture. It is to be expected, then, that youngsters like this will have difficulty in recognizing their social responsibilities toward their group, for their "friends" are in actuality only short-term acquaintances, if not almost total strangers. Not only did last year find them in an entirely different group, but next year, or the year after that, probably will also. We are, indeed, fast becoming a culture without roots.

Other factors, of course, have also contributed to the lack of polite consideration, the absence of group feeling, and the lack of "audience consciousness" manifested by some of our school and social groupings of young people. Our mechanical mechanisms of entertainment have given our children inadequate practice in responding to face-to-face situations and have even misled them by giving them active practice in types of behavior that are impertinent and rude as soon as a live performer is involved.

A radio, for example, can be, and often is, switched off while the speaker is in the middle of a sentence or even of a word. And even if we do not turn off the radio, we frequently give it only half-hearted attention while we are semi-occupied with other activities or with personal conversations. This same behavior, acceptable though it may be in the presence of an inanimate object such as the radio, becomes intolerable if accorded a speaker in a school auditorium or on the public platform.

The movies, too, encourage self-centered attention only to personal convenience, with entrances and exits by the audience during the performance taken as a matter of course, and even popcorn and petting passing relatively unnoticed. These same types of behavior which are acceptable—or at least accepted—in the darkened movie theater, with its

mechanical presentation of art and music, become extremely discourteous when they occur in the concert hall or in the presence of living stage actors and actresses.

These variegated factors have been reinforced by some of the characteristic and dominant features of our modern economic and social structure. We have increased the size of our population and crowded ourselves together into duplexes and apartment buildings at the same time that we have been perfecting ourselves as individualistic members of an extremely competitive society. Courtesy and consideration for the other person were once accepted as essential marks of the educated gentleman; but in to-day's culture, in which we all tend to regard each other as rivals, they are now often looked down upon as signs of personal weakness and "lack of backbone."

All of these factors in our culture have tended to place much of our behavior to-day on an impersonal rather than a personal basis; and precisely because so much of our modern behavior is as it were incognito, it has become not only impersonal and devoid of social sensitivity, but also downright discourteous and selfish as well. With the philosophy of impersonal human relationships that we have developed, and living as we do in the circumscribed environments set by our metropolitan culture, it is little wonder that we frequently find it extremely difficult to live at peace with ourselves and with one another and that we feel that many of our young people and our neighbors are crude and lacking in elementary courtesy.

"Blood will tell," said our grandparents, believing that pleasant manners and gentlemanliness were congenital qualities that were bred in the bone. Because these characteristics are just as important and desirable in the individual to-day as they were a generation ago, most of us are still interested in the sometimes painful process by which a child learns the many things that he must know in order to take his place in our social order gracefully, with a minimum of frustration on his own part and with the maximum of pleasure on the part both of his neighbors and of himself—in other words, how he achieves the "good breeding" of which the bygone generation so often spoke.

Even before the present period, with its emphasis upon scientific child care, our grandparents observed that certain children had little difficulty in making this transition from selfishness to coöperative social living, while other youngsters appeared unable to make it. The way in which this change took place seemed rather mysterious, moreover, for the process was incompletely understood; hence our elders assumed that the traits that contributed to a pleasant personality and a spirit of coöperation were inherent in the individual and in his family, or, as they put it, the child was well-bred.

Now, however, we recognize clearly that such personality traits as coöperativeness, consideration for others, and social sensitivity, as well as their opposites, are *not* a matter of biological inheritance in the same sense as the color of one's eyes or the shape of one's nose, but that they are *learned* reactions which are acquired by means of the same simple basic learning procedures as skill in tying a shoestring or in learning to eat with a fork rather than with the fingers.

Like any other highly developed skill that is an essential part of our daily lives, good breeding is more conspicuous in its absence than in its presence. By their very nature, the results of good breeding are unobtrusive. In the well-bred person, considerate responses have become automatic through many years of observation and constant practice. The individual has tipped his hat, stood in line, given another more room when crowded into an elevator or on a bus, said "Thank you," "If you please," and "I beg your pardon," or "Excuse me," so often that he now makes these responses spontaneously, even without conscious thought. For him these polite considerations of another's welfare—in small matters as well as large—have become the outward expression of an inner spirit of coöperation and friendliness; they have now become a way of life.

The well-bred individual, having learned considerateness and coöperation through constant practice as a young child, will not, as an adult, be guilty of the many inconsiderate and thoughtless acts that make certain aspects of our modern close-knit life so unpleasant. If he lives in close proximity to others, for example, as most of us do, the well-bred indi-

vidual will not blare his radio or run his dish-washer, sewing machine, or typewriter in the dead of night—with supreme indifference to the discomfort of his neighbors.

It is obvious to any thoughtful individual that such ways of acting are deplorably common. Observe the behavior of people, not only in their personal lives at home, but in the department stores (particularly on sale days or at bargain counters), in the movies, at concerts, at lectures, on the highways (especially in a line of cars at stop signs), while standing in line at a ticket window, when ordering their meals from a harassed waitress, at the check-out counter in the supermarket, or at public gatherings of any sort.

Far too often their behavior is not that of well-bred people. Our grandparents called it selfishness; now we speak of it as egocentric behavior. It is still the same. Now, as formerly, it is thoughtless and inconsiderate conduct that stands between us and a cultured and harmonious life together, the chief difference being that now, because we have lost our feeling of group unity and nevertheless are crowded into close-packed communities where we cannot escape from one another, the need for mutual courtesies, thoughtfulness, and consideration for one another's welfare is even more pressing.

When these inconsiderate and thoughtless actions occur, they are not new or isolated bits of behavior in the individual; they are merely adult counterparts that continue the long train of self-centered and thoughtless behavior patterns begun in the nursery. The well-bred individual will never, remembering only that *he* is inconvenienced, honk his car horn at every stop light or upon the slightest provocation, unmindful of the hundreds who have to hear the noise. The driver who thus blares his horn instead of using his brakes, his patience, or his good sense was, no doubt, the adolescent of a few years before who drove the family car to an abrupt halt with screeching brakes in front of his girl friend's house and loudly and impatiently honked his horn—because no one had ever instructed him as to the proper way in which to call for his date. And a few years earlier still, he was in all probability the youngster who went over to his chum's house and, instead of knocking, yelled through the window for his friend to come out to play, disturbing with his noisy

shouting not only the boy's family, but the entire neighborhood and every one who chanced to be within earshot. Such an individual has simply retained these childish, self-centered ways and has never learned more socially mature and acceptable forms of behavior.

Unless these desirable personality traits of consideration and thoughtfulness for others are learned *early,* unless they are absorbed, as it were, in the process of nursery living, they will be at best but incompletely learned, and they will then fail to serve as basic motivation for desirable adult behavior. Unless very early in the life of the individual there are nurtured the spark of an inner compulsion based upon respect for the rights of other people and the glimmerings of insight into the legitimate needs of one's fellow man, there can be no genuine motive in adult life for coöperation and considerateness.

Not only must this training be begun early in life, but because children reflect the unspoken attitudes as well as the deliberate teachings of their elders and teachers, this early learning can be assured only through courteous treatment, which respects the growing child as an individual, from every one with whom the child comes into contact.

Later and more formal education can give but a gloss to the individual at best. It can enable him to hold a pose by making it possible for him to recognize intellectually that certain kinds of behavior are self-damaging and not socially acceptable, but this later education can never make up entirely for a lack of early childhood training.

Only through continual training during his early years can the individual achieve so thorough an understanding of fundamental human relationships and so high a degree of perfection in these socialized traits that the performance of these basic courtesies becomes automatic, almost compulsive, so that he cannot be otherwise than courteous even if he would. Through continuous observation of those within his own family and all other individuals whom he meets, he has learned that there is no other acceptable way of behaving.

This learning to share, this learning to respect genuinely the feelings and attitudes of others, is possible only for an

individual who has a basic *sense of security* and of being wanted in his family and in the larger social circle. The individual who still feels insecure in his own position in his social or economic group does not, as a rule, feel free to share with others the things that he feels he must first of all fight to get or to maintain for himself. The real tragedy of early privation in children, therefore, be it economic or emotional, is that they often tend to develop therefrom patterns of aggressive behavior which, although suitable under the conditions in which they are functioning at the time, will cause the individual to be out of harmony with the more discriminating social environment in which he may live later.

In the case of those of foreign descent, for example, many first-generation individuals, and even some of the second generation, find the struggle for Americanization difficult. Many of them thus develop egocentric and individualistic behavior patterns that were suitable, or even actually necessary, for the crude environment of their early days, but that are inappropriate, and difficult, if not impossible, to overcome later when a place in a higher social plane has been achieved. Many such individuals have found their vertical migrations up the social scale so demanding in competitiveness that they have come to confuse consideration for the rights of others with weakness.

Most of us know adults who, because of special abilities or exceptional ambitions, have overcome great personal and social handicaps. More often than not, however, in so doing they have also been forced to develop habits and use techniques and methods that, although these have contributed toward making them a sturdy success, have left them deficient in basic humanity as well as in polish. In this type of successful man, the overbearing manner and the loud voice are merely the long shadow of the belligerent boy whose raucous and uncalled-for "I can lick you," backed by a ready fist or a kick, gave him the necessary advantage.

Good breeding, then, does not depend upon biological inheritance. It depends, rather, upon *social inheritance,* upon the social environment into which the child is born and in which he attains adulthood.

It is, nevertheless, almost as difficult for an individual to find a substitute for an undesirable social inheritance as it would be for him to find an adequate substitute to make up for some lack in his biological heredity. As many have found to their sorrow, it is almost as difficult to change one's personal habits or one's table manners as it is to change the color of one's eyes—definitely more difficult than to alter the size of one's nose or the color of one's hair! Later in life the time and energy required, the outside help needed, and the constant personal vigilance involved in acquiring this inner socialization to compensate for an earlier omission in training are so great that few individuals have the courage, vision, and persistence to achieve it. Most of these people, therefore, will content themselves with a lower level of social conduct and remain, unfortunately, unable to achieve coöperative behavior except when the man with the big stick is clearly visible. They are thus capable of being considerate of others only when they feel that the other man is sufficiently important, only when they can be made to feel that the luxury of courtesy can be traded for some immediate and tangible dividend. Seldom, if ever, can this later grooming approximate that inner compulsion which is the basic sign of good breeding.

The main reason for this great difficulty in re-training adults in basic personality traits and behavior is that they themselves cannot recognize the need for a change. The self-made man who has gained his success at the expense of the well-being of others is again merely the child, now grown up, who won the game or brought home the good grade regardless of the cost to himself or to others.

It is true, of course, as such an individual will be the first to point out, that he gives others the same consideration that he asks for himself, and that he makes no demands on others that he does not make upon himself. In the main he has learned only too well the intense lessons that our competitive schools and society teach. He fails to remember, however, that civilized people carry on their competitive contests according to recognized rules of the game—they do not merely "slug it out."

Generally, these ill-bred individuals are able to see only

the material rewards that their aggressive, selfish behavior has brought them, and they are entirely incapable of appreciating the real cost to others upon which their small victories are based.

Even the well-trained individual, of course, may have lapses, may forget himself if absorbed in other behavior; but he, as a rule, will respond promptly to small hints and strive to make amends.

The ill-bred individual, on the other hand, does not care when he inconveniences or disturbs others, and, in fact, usually cannot even recognize his own behavior as undesirable. He is unable to understand that although *he* may enjoy loud jukebox music at midnight, *others* may have spent years developing the ability to make finer musical discriminations and hence may find his over-loud radio truly disturbing both to their work and to their sleep. Again, because he beats his own children and threatens them with the policeman in order to frighten them into obedience, he may be incapable of comprehending other parents' objections when he uses these same measures with *their* children; he simply cannot realize that some children may have been trained to respond to less crude or brutal methods of control.

Excitement, drink, illness, and any change in the external authority are almost certain to accentuate the basic egocentric behavior and make the ill-bred individual even less sensitive than usual to the needs of his neighbor.

Again, he is the individual whose behavior may be expected to go from bad to worse when he travels. Whenever he leaves his community or his small group, where he does recognize the necessity of maintaining at least minimum standards of social decency, he also leaves his motives for even a pretense of mature conduct, for he is wanting in personal ideals and inner motivation. Thus, the tourist away from the standards of his own little social world, the convention celebrant off his good behavior and on a spree, and the social snob in his private dealings with individuals he considers below his self-assumed class, are often shocking examples of ill-bred behavior.

The child whose basic behavior patterns change as soon as the parental back is turned, or who immediately puts his

feet up on the desk or gets into mischief when the teacher steps out of the room, has not yet built for himself a code of behavior sufficiently strong to carry him through unsupervised periods. Unless he learns to do so during his early years, he will be another of those adults for whom the man with the big club becomes a necessity for civilized living. He will be the type of adult that only official "quiet hours," clearly defined, conspicuously posted, and rigidly enforced by some community authority, can restrain from being a blatant nuisance to all who must live near him. He is one whose neighbors would do well to mark their yard-lot boundaries with a hedge or a picket fence and to keep it always in good repair.

A recognition of the fact that the solid core of human personality has its beginnings in the first few years of life reëmphasizes the need for good breeding from babyhood on, this time from a psychological point of view. It is during the nursery years that we lay the foundations for our pleasant and our unpleasant personal traits; it is at this point that our well-adjusted or our maladjusted and neurotic individuals are made.

A comprehension of these facts regarding the development of behavior patterns makes clear the futility of postponing "character education" and personality training until some special period of life. It makes plain to us, too, the folly of forcing our schools, our churches, and other social and educational institutions into the unprofitable and unenviable position of having to devote the major portion of their energies to remedial and corrective measures; and it places a larger share of the responsibility of education for good citizenship clearly upon the *family* and the *home,* where it rightly belongs.

The well-bred child, now as in the past, is that youngster who, from his very earliest years, has been consistently trained by his family, through imitation and constant example as well as by verbal precept, to be so secure in his own world that he can well afford to be sensitive to the needs of others. He has learned through convincing personal experience that there are toys and material possessions enough to meet all of his needs, and that the source of his psychological security—the love and affection of his parents and family

—is boundless. He has realized that it *is* true that most of the good things of life are multiplied when they are cheerfully shared.

The well-bred individual is not only able to recognize the rights of other people, but he also knows acceptable and unobtrusive procedures to utilize in order to contribute a share toward satisfying their legitimate needs. He is quite willing to be accommodating; and if necessary, he is willing to go even further than halfway in order to meet the other fellow. Furthermore, even at such times, his generous tolerance makes this sharing which constitutes our common social courtesies seem not a duty, but a privilege.

"Good breeding and polite manners," said our grandparents, "distinguish the gentleman from the boor." Now that many of our broad social institutions are concerned primarily with the training of effective participants in competitive enterprise and no longer have clearly-defined ideals in the area of human relationships, the home, now as never before, stands out as the last refuge in which the individual who would be well-bred can get his training. And, in a social order as intricate and complex as ours has become, never has the need for well-bred children and men and women been so great as it is to-day.

ALL THE WORLD IS QUEER BUT THEE AND ME*

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"ALL the world is queer but thee and me—and sometimes I think even thee is a little queer."

These are humorous little phrases, and we say them pleasantly and on the proper occasions, but they really represent the philosophy by which we live. They are symbolic of the blind spots we have in regard to ourselves, and betray the fact that it will be difficult or impossible for us ever really to be helpful to another. Not until we see ourselves as we are will we be in a position to see the other fellow clearly. As long as we travel in another world, with different motives and goals, as long as we are not seeing and talking *across* the table to our patients and clients and even our associates and relatives, just so long will we be involved in dissipating rather than conserving human resources.

I wonder how many of us have ever stopped for a single minute to wonder what makes us behave as we do? Why do we dress as we do rather than in some other fashion? Why do we marry or why do we remain single? Why do we show initiative and self-reliance, or why do we wait for some one else to take the lead? Why do we belong to the church that we do, and why are we provoked or enraged or made comfortable by the things that affect us in these ways? It might not even be amiss to wonder why we are concerned about conserving human resources.

I am sure many of us are aware of the many desirable qualities that we have, just as we are aware of the many undesirable qualities that every one else has. Of course we

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are not blatant or even obvious about letting people know that we know or are aware of this vast discrepancy between us, but in effect we depart from the temple thanking God that we are not as these other men are. There is a certain smugness and sense of virtue we have by reason of our patterns of behavior, and there is a certain looking down our nose—even if well camouflaged—which few of us will have the temerity to deny. If we have been well taught, we will display tolerance to this other person—but the very word "tolerance" implies something of the vast gulf between us.

Perhaps, through the magic of words, something *may* penetrate our fields of awareness that will erase this gulf—which exists only in our own imaginations. I shall attempt to clarify not only the implication, but the bald statement that we are all in the same boat, whether we like it or not.

I have yet to find the human being who does not operate on the basis of one and only one basic principle. This basic principle extends into every nook and cranny of his life, his choices, his patterns, and his reactions. It makes one man interested in conserving human resources and another man lie and cheat and another have hallucinations. There is much speculation about the purpose of life. Many people believe that they have the answer. I, too, think that I have the answer. The answer is contained in the statement of the basic principle of all life: The immediate and ultimate goal of every person is neither more nor less than the avoidance of anxiety. Everything we do is calculated to forestall anxiety or to deal with it if it arises.

It is clear that this is the case when we change our clothing with the seasons, or invest in life insurance, or earn money and buy food, or obey traffic regulations, or pay heed to the rituals of the church of our choice, or leave the car in the garage rather than take it out in a dense fog, or call the doctor when we have a fever, but it is not quite so clear that the same motive is operating when we are simply our usual selves, operating in our own little groove, seeing our usual friends, doing things in our accustomed way, succeeding or failing, being lazy or industrious, being compliant or rebellious, being considerate or inconsiderate, being shy and seclusive or aggressive and exhibitionistic. However it may *seem*,

clear and honest observation will lead one to the conclusion that it is the effort to remain free from anxiety, albeit momentarily, that determines what each of us does from the cradle to the grave.

One of the most illuminating experiments one can engage in is to do something contrary to one's habitual pattern and see what happens. If you are accustomed to being reticent, try being exhibitionistic. If your habitual pattern is to be honest or trustworthy, try being dishonest or sly or undependable. If you are customarily a follower, see what happens when you step out and become the leader or organizer. Let's say that you are usually the one who is walked on—taken advantage of—and now you decide to be the one who does a bit of trampling on others. Or let's say that you are the one who is looked up to as having the right answer, and then your rôle changes so that no one pays any heed to your opinions. It might even be occurring to you at this point that those who are downtrodden or who are failures, or those who are chronic law-breakers, are in the same predicament as the rest of us: This is their habitual pattern and to vary from it is to court the same kind of anxiety that would occur in the person who tried to change his pattern from that of solid, substantial citizen to that of local ne'er-do-well or bank robber. Once we have established a pattern of behavior, we are going to stick to it consistently.

Each one of us *has* to be true to himself—and by that I mean that he must follow his habitual patterns of behavior —or he will surely have to deal with anxiety. This, then, brings us to the very important questions: What is myself? How did I happen to become this very special person? How did everybody else happen to become the very special person that he is? As we begin to think about it, the fact that there are no duplicates almost staggers one. There really are no "insane" or "criminals" or "behavior problems" or "psychoneurotics" or "normal people," but only individuals and very special individuals at that. We cannot begin to deal intelligently with people until they no longer fall into classes, but are fully understood—as individuals—individuals who are doing their level best (given their beliefs and

assumptions about themselves and about the people around them) to forestall anxiety or to deal with it once it has overtaken them.

When an individual is born, it is not a foregone conclusion what kind of person he is going to be. The more we know about the effects of environment in shaping the character structure of people, the less room there seems to be for heredity. Perhaps the most that can be said for heredity is that along with the particular type of chemistry with which each of us is born goes a rather nebulous general type of reaction which may be called a "reactor" or a "non-reactor." We do know that the proteins of individuals differ, and when an individual has a preponderance of one type, he has the capacity and the pattern of reacting, say, to foreign proteins, and if he has a preponderance of another kind of protein, he tends to react minimally to these foreign proteins.

Beyond this basic inborn quality, and given also the factor of inborn intellectual capacity, the individual who finally emerges and is known as our self or our neighbor or our spouse or our child or our parent or our client or our patient will become whatever he becomes, not by choice, but by necessity. He develops the only kind of character structure—we all develop the only kind of character structure—that it was reasonable to develop. Any other combination of qualities would have been impractical or fantastic—often actually dangerous.

Let us look at a few concrete examples, and this may become more obvious.

R.S. was born to parents who separated shortly after his birth. His mother took the baby with her back into the home from which she came—the home where lived her parents and her older sister who had also made a venture into marriage that lasted but one week before she was back in the parental nest. R.S. grew up just like any other child—constantly surrounded by people who had attitudes toward all manner of things and who reacted in no uncertain way to all of his behavioral experiments.

There was a firm solidarity in this little family unit of five people—the child, one old man, one old lady, and two

women no longer young. Their home was their castle and no one trespassed into it, and they did not feel secure enough in the big, wide world to venture into it. Each one had his job and his duties: Grandpa worked and earned as best he could until he was too old and sick; Grandma did the cooking and marketing; Auntie washed and ironed and cleaned; and Mama went to work daily in the cigar factory. Every one took care of R.S., the little prince and darling of the home, but Auntie really had the major responsibility for him. Unfortunately, she was also the most domineering and the least favorably endowed intellectually of the group.

Before he was very old, it was quite clear to him that there were certain things that were very bad: his father, playing outside his own back yard, carrying tales about the family to outsiders, stealing, drinking, having anything to do with strangers, and any activities that might result in physical injury of even the slightest degree. As he grew older, there were still other areas that were "bad"; having any contact with girls was one of these. In fact, anything that did not include the family was bad.

There were other things that were very desirable, as evidenced by the enthusiastic coöperation of the family. Some of these were being completely and totally dependent on the family for waiting on him in all of the details of his wishes or wants; practicing music lessons; stuffing himself with quantities of food served to him whenever he took the notion to eat—which was frequently; remaining a little child in all areas involving experimentation outside the family. He slept with his mother until he was in his mid-teens and was twice her size. When he wet the bed, his mother moved him to the dry side while she then slept where it was wet. Another thing that was good was to work and earn money, but there was no necessity for relieving any of the financial load of the family with it.

There were, to be sure, certain tensions, because he was far brighter than any member of his family, and he grew to be quite rebellious in many ways by reason of their tremendous need to boss and dominate him, so that he tended to regard their opinions as worthless and those of any stranger, of whatever qualification, as valuable. This brought

heaps of abuse on him from his family, but he knew that they never meant what they said because they always melted when he brought home some ice cream, or, in fact, if he merely wanted them to wait on him. His disregard for their opinions, however, was never in the area of moral values, but only in matters of lesser importance.

Another thing that was taken for granted in his home was that thinking out a problem or arriving at a conclusion after two and two were available to be put together, just was not done. In fact, conversation—exchange of ideas and opinions—was unheard of. The answers were handed down from generation to generation, and what could not be answered by this method had best be left alone. But R.S. knew that there were more answers than that, so, since his own grey matter was not to be used, he believed some one else must have the answers.

As he grew older, he was aware of being different from others, but he thought it was because he was fat. He was sure that there was nothing that he did wrong—he dressed correctly, he talked fluently, he worked like other people and earned fair money. He just never seemed to be "one of them." Finally there was only himself and his aunt left of the family group, but never did he waver from his allegiance to or his dependence on her.

Then came the rise of Hitler and the war in Europe, and conscription was upon us. Suddenly, one day while watching a game at Yankee Stadium, he collapsed. He developed a "nervous breakdown" which expressed itself in pallor, clammy skin, rapid heart, and a sense of imminent death. He rushed for medical help. He went here; he went there. Each new doctor helped him and relieved him for a while, but soon the devastating symptoms returned—and others, too. He did everything any one suggested—from vitamin injections to colonic irrigations to reading Mary Baker Eddy. He changed his diet; he took pills; he exercised—there was nothing he did not try. He even went to a psychiatrist at some doctor's suggestion. Then followed a year or more of sessions twice a week. He no longer went from one doctor to another.

Gradually he was brought to see that it was the threat of

conscription and of war that had precipitated his anxiety reaction, which expressed itself in physical symptoms. How could *he* do physical labor? How could *he* be in a position where he could not come home nights? How could *he* get along without his family? How could *he* bear to be exposed to physical hardship and danger?

Slowly he began to see that there was no realistic reason for his being different from others, but only his long-accustomed and habitual attitudes toward himself, and he began to do various things that were more in keeping with the actual situation. He began working away from home and coming home only on week-ends; he started a bank account instead of putting all his money into his stomach or on the horses; he began to pay off old debts; he began to believe that even a fat man might get by with women and that perhaps he might behave like a sexually mature person. Within two years after he became ill, he was married.

Time went by, and eventually his wife found her way to the psychiatrist, too. She came first not for treatment for herself, but for help in dissolving the marriage, which had become intolerable to her, but she finally stayed on her own account. Her complaints against R.S. were endless: Before marriage he had behaved in a most acceptable manner to her, but almost immediately thereafter he had changed until she hardly recognized him. He took no financial responsibility for the family, but seemed to be interested only in being the purveyor of gifts; he used to look up to her, but then began to show complete lack of respect for her opinions and judgment; he demanded incessant waiting on; he was constantly, constantly eating; he even continued sending his laundry home to his aunt, who washed on the board despite the fact there was an electric washer and a maid in their own home; he seemed constantly apprehensive in regard to physical accidents or injuries; she could never discuss any problem with him and never could lean on him for any opinion or advice or support; he could not tolerate any anxiety or lack of certainty in her; he was blatantly vain and exhibitionistic in his field of work; he seemed outgoing, but never made any close friends; he was interested in nothing but being complimented or amused or getting a laugh out of

people; he knew nothing about the use of either time or money; when she demanded that he think something out for himself, he complained of "symptoms"—funny feelings in his head.

She had tried suggesting; she had tried demanding; she had tried shaming; she had tried crying; she had tried everything she could think of—but he never made any changes. There were times when he made her feel practically homicidal and then she lashed out at him with physical violence. This was too hard on her because she had never behaved in this fashion before, but neither had she ever encountered a person like him before. But her rages left him essentially unperturbed and he seemed never to believe that she meant what she said. He twitted her about her ugliness and her lack of feminine charm and wiles, and yet made her the man of the house by what he failed to do. Sex life was most frustrating.

He did not appreciate her, her feelings, her judgment, her strength, her self-denials, her weariness, her efforts to make things work out, her financial support—he took everything for granted and never put his shoulder to the wheel or pushed, even in the most obvious places. She couldn't take it any longer; recently she had felt so disturbed she had broken out with a rash all over her body.

The story was long—and one saw all through the recital the feelings of rage, of outrage, of virtue unrewarded, of contempt and of disdain for the man who was her husband. But he, too, was unable to fathom her, or to see what was amiss with himself. What more could she possibly want? He worked steadily; he paid most of his own expenses; he gave her many gifts; he didn't run and carry tales even to the psychiatrist about her violent rages when she was not pleased with him; he had never struck her; he didn't gamble; he didn't drink; he didn't even look at other women; in fact, he was sure he loved his wife more than she loved him; she did not appreciate him or give him the sense of importance a wife should give a husband. She was always right—and he felt smothered. As for sending his laundry home, he would feel like a heel if he took away from his aunt the only remaining reason for her existence.

The farther one went into the story, the more details one

learned, the more apparent it became that each one of these people was merely being himself—the self that had been formed in childhood out of the necessities of the situation. R.S. was infantile, dependent, unsocialized, fearful, rebellious, without the usual goals for an adult—and all because to have been anything else would have made it impossible for him to fit into his family situation. His wife was strong, industrious, independent, trying to contribute in the fullest measure, because these were the qualities that were demanded by her family situation. Each one had formed an image of himself out of the necessities of the situation, and this image once having been formed, each pursued it willy-nilly throughout life.

The curious thing, however, is that despite the vast difference in their overt behavior, each one thought well of himself, indeed considered himself highly virtuous. A sense of virtue is always present when one feels that one has measured up to the demands and specifications set up by those people who were significant to one while the psychological image of the self was being formed. A child may behave in an outrageously grown-up fashion—being far too socialized for his years—but if the significant people do not approve of him, he will have a sense of guilt rather than of virtue in his character structure. In other words, a sense of guilt or a sense of virtue has no other basis or standard than simply the attitudes of the parents. A child may steal, but if stealing is highly regarded by the parent, the child will feel virtuous rather than guilty. Likewise, if dependency or sexual infantilism are highly regarded by parents, and the child fulfills these requirements, he will have a sense of virtue rather than of guilt or shame over his traits.

This case illustration demonstrates many more things. Not only did each of these people feel virtuous, but he also felt sinned against by the other. Each one felt helpless to deal with the other because traits that they had developed in order to get certain responses from significant people in their childhood—acceptance, love, immunity from punishment, attention—no longer got the correct response in this new situation, marriage. They were both as helpless as we are in our dreams or our nightmares when we go through

the same motions we have always gone through in trying to scream or to run, but we cannot move or no sound can be made.

They also illustrate another basic principle of behavior—namely, that when either one of two situations arises, anxiety will result. In the first situation anxiety arises in any individual when the integrity of his structural image—either physical or psychological—is threatened. The thoughts of conscription and of war threatened both R.S.'s physical and his psychological image. In the second situation, one finds anxiety arising whenever one keeps his structural image—either physical or psychological—intact, but it fails to function properly. The wife kept her psychological structure intact—she remained strong, industrious, competent—but it did not get the proper response; it did not generate appreciation, acceptance, coöperation, or helpfulness.

They further demonstrate what may happen when anxiety develops—when the structure is either threatened or broken, or the function of the structure is disturbed. Anxiety as anxiety is too painful to stand for very long; therefore, we convert it in one of three ways: We convert it into physical symptoms—as did both R.S. and his wife; we convert it into an attack reaction—as was done by the wife in her wild rages against her husband; or we convert it into withdrawal or paralysis or sham death behavior—which this particular case does not illustrate, but which is one of the most common responses to anxiety. We see it in sulking; we see it in stage fright; we see it in depression; we see it in schizoid withdrawal.

The rage reactions that arise out of anxiety may be of any degree from a mild annoyance to homicide. There is no difference in quality, but only in degree. The situation that precipitates the anxiety may seem trifling enough—perhaps it is only the implication of questionable judgment, or failure of complete integrity, or absence of physical charm—but if it is one that threatens the structure of an individual or interferes with correct function, the ultimate rage reaction may result in murder.

Perhaps the most important thing for us to realize is that in this whole area of behavior, the most important things with which we deal are the feelings of guilt and of virtue.

Most of us have formed a character structure that is in its major aspects reasonably acceptable to our parents and we, therefore, have a sense of virtue. In every detail in which we regard ourselves with favor because this detail is acceptable to our parents, we may say that we have a sense of virtue, and we go through life bent on only one thing—keeping ourselves free from anxiety, so that we must see to it we keep our structures intact. We must avoid the guilt sense that attends breaking our image of ourselves. We cannot afford to lose our sense of virtue.

Society is enough like our homes—particularly if it is a relatively homogeneous community—to let us keep our structures intact and functioning properly without too much difficulty or disturbance—*i.e.*, we get the correct or expected responses from our behavior. But when we are thrust into situations from which we cannot escape, or feel that we cannot, such as war or even marriage (for one's partner is always more or less of an unknown quantity), or some separation from the familiar environment of childhood, we are just as likely to have anxiety as any one else. The people with recognized symptoms which classify or label them are not a different breed of humans; they are merely individuals whose experiences with society have been such as to threaten their usual or habitual patterns of behavior. As a result they have felt anxiety and have converted it into symptoms.

All of us are neurotic—and by that I mean that we are living unrealistically. We act in any situation compulsively, according to our established patterns, as if we were still children behaving for the benefit of parents.

To the extent that we are measuring up to our idealized image, the one established as standard by our parents or other significant people, we feel virtuous, and under circumstances in which others around us vary or differ from that standard, we display a smug superiority. The intact image is practically synonymous with smugness and a sense of virtue. Each of us, however, is a candidate for a madhouse or a prison once our sense of virtue has been outraged. If we do not get the right answer back, we cease to be reasonable beings. Anxiety possesses us and we react with the fury of a trapped animal, or we develop physical symptoms, or we

withdraw into psychotic impotence. The person who has never experienced this feeling is one who up to this moment has been successful in maneuvering himself into an environment that provides him with the anticipated and expected response. But none of us has any guarantee how long this may last.

As long as we do not understand the basis of behavior, we are liable to fall into the error of regarding behavior as right or wrong; we pass moral judgment upon it—and we fail to evaluate it realistically. Neither wood nor coal nor iron nor bread are good or bad; each one simply functions according to its structure. What we are, we must be, and we must behave accordingly. This does not mean that we are helpless to make any changes, but changes are difficult and fraught with more anxiety. People do not tend to make any changes unless they have come to the point where they are convinced that their ordinary patterns are inadequate. Likewise, insight into the facts of their behavior patterns will provide the best assurance of change to a type of behavior that is more realistic.

All of us need to appraise situations to determine what behavior is called for in any given situation, instead of blundering on compulsively according to our established patterns, failing to achieve the expected results, and then being good candidates for being sinned against—feeling outraged and resentful. These are the same people who make every one who does not conform to their standards—or, more correctly, their parents' standards—feel like sinners, stupid wretches, or criminals. There is nothing quite so unrealistic, quite so fantastic, quite so neurotic, as a sense of virtue—and nothing that can limit the personality more or inflict more cruelty on another.

If we would conserve human resources, we need to lose first both our sense of guilt and our sense of virtue. Either feeling is too wasteful as well as too unrealistic. With these feelings we court trouble for ourselves, and are surely dispensing unnecessary punishment on others.

HOW THE SOCIAL WORKER CAN CONTRIBUTE TO THE PROMOTION OF MENTAL-HYGIENE SERVICES IN THE COMMUNITY*

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AT a time when, on the one hand, an expansion of mental-hygiene services is in progress and, on the other hand, personnel and other resources are limited, it is especially important that social workers keep an eagle eye on the developments in this field, in order that they may all eventuate constructively not only for the mentally ill, but for the mentally well also.

In a narrower sense, mental-hygiene services may be identified as psychiatric services. They include hospitals for the treatment and continued care of the mentally ill. There are also general hospitals with special facilities for the treatment of early cases of mental illness that will return them to the community without recourse to mental hospitals, and where, pending hospitalization, the mentally ill may find a hospital atmosphere and a constructive experience. They include clinics for the treatment of children and adults who probably will never need hospitalization; for the guidance of those in need of the kind of therapeutic help that a mental hospital can give; and for those who have benefited by such hospital treatment to the point where they have returned to the community.

Mental-hygiene services in this narrower sense might also be thought of as including consultation with a variety of community agencies whose clients may never need specialized psychiatric help. Such agencies would include the schools, the courts, and public-health, recreational, and general-medical agencies. In this sense also mental-hygiene services would include public education for mental health.

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It may seem paradoxical to speak of these as mental-hygiene services in the narrower sense, but you will recognize that the services listed are primarily psychiatric throughout. If the social worker is to contribute to the promotion of mental-hygiene services, however, no matter how narrowly they are conceived, such services must be seen in their relation to mental hygiene in the broader sense. This would take into account the needs of the normal public, of the newborn and young child for whom the obstetrician, the pediatrician, and the public-health nurse are the most consistent mental-hygiene resources.

I hesitate to add, however, that all too often their activities are anything but mentally hygienic. Their work potentially begins long before the child is born, but this opportunity, as a rule, is missed. Their services may be performed in isolated bits, or with the obstetrician, pediatrician, and public-health nurse acting as a team. Far too often they are performed as isolated bits. These services may be performed with a vista in mind covering the future years of the child involved, but too often considerations of the immediate situation gain priority and cloud the longer perspective.

The failure to give the child the experience of an intimate and dependent relationship to the mother in infancy often results from the mother's surrender to cosmetic considerations and the convenience of the bottle.

In later years the social worker again and again receives the backwash from this early neglect of the emotional needs of the infant, and it is by mobilizing his experience that its effects may be reduced, if not overcome. The anthropologists tell us that it is during this early period that the characteristics, customs, and basic attitudes of families and other cultural groups become fixed more or less irrevocably. So it is during this period that the greatest opportunity exists for contributing to the wholesome development of the child without the impediments of useless or obstructive customs.

But this is not to imply that the opportunity ends here for those who are dealing directly with normal children or for the social worker. For twelve years the child becomes the concern of a professional group that theoretically is preoccupied with child development, and from then on, for

the rest of his life, industry figuratively or literally takes a hand either in providing him with satisfying work attuned to his abilities or else undermines his mental health by not providing him with work from which he can get satisfaction. Again it is the social worker to whom come the breakdowns resulting from this neglect and who is in a position to interpret the destructive factors to the community and to take steps for their elimination.

There are two other groups in the community who are consistently concerned with normal individuals. First, there are those whose primary preoccupation is recreation. Far too often the benefits of a recreational program are for those who can take them without requiring readjustment to the patterns of the recreations that are offered—commercial or otherwise. Again it is the social worker who encounters those who have been unable to meet their recreational needs through the existing facilities, and it is the social worker who is able to interpret to the community its failure to provide this basic element in personality growth and vigor.

The other group that deals with normal individuals is the church. The church is not only called upon for counsel in the small and large crises of life, but has much to do with the shaping of the family structure and the social atmosphere in which the individual grows and lives. Many of its services, especially those that have survived the trial of centuries, are supportive and stimulating to healthy personality development. Some, especially those that grow more out of the personal weaknesses of the minister, have the opposite effect. In the latter case particularly, the social worker, through her experience in a community agency or through her affiliation with the social-work functions of the church, is in a position to turn the activities carried on under the auspices of the church into a constantly more constructive channel.

So far what I have said has to do primarily with the needs of normal people. The social worker, by the very nature of his task, which is concerned with some kind of social breakdown, be it large or small, is a crucial element in the protection and the promotion of mental health. The deeper emotional distortions of to-day are founded upon the superficially disturbing problems of yesterday. Yesterday's prob-

lems were the realities of life—economic problems, physical handicaps, dislocation, family disruption. They are the problems that come into the daily work of the social worker, and it is the wise handling of these related problems that removes or softens their traumatic importance and prevents the formation of distorted emotional reactions which may handicap the individual for years to come.

So many of these realities—not forgetting bad luck, mental deficiency, and acts of God—are the failures of society to be really civilized that when the social worker attacks them he attacks all the people. Too often he has failed to recognize this and has been surprised that society fails to reward with good will his reformative effort. He must expect such a reaction, and he will expect it if he knows the dynamics of his profession. But that does not excuse lack of finesse, and he must beware lest he be motivated by the satisfactions of righteousness and martyrdom, instead of using his skill to promote the advance of civilized society as he does with his clients. He often arouses more hostility than is necessary.

Fortunately the social worker's job, as a rule, deals both with the potentially traumatic situation of to-day and with the ineffective emotional habits of yesterday; he is, therefore, in a position to serve as a bridge between the two, to the end that the community, its families, its industries, and its many services may be made more mentally hygienic. The social worker knows that all of these fields and situations to which I have referred are the concern of mental hygiene because his client says so in unmistakable terms. Figuratively, the client points back to them fairly vividly, and the social worker must be constantly aware of his pointings, as well as of the immediate opportunities for work in each particular case. The case may offer rather limited prospect of psychological renovation, but still may provide the strongest possible evidence of the community's failure and serve as an incentive toward making the community a better place in which to live.

The social worker will, however, tend to miss these pointings of the client unless he maintains a broader orientation, and the larger the community in which he works, the more difficult this becomes. He must maintain as a background

for himself some kind of well-ordered concept of how the community may serve its people.

Back of this concept should be an understanding of how community services arose—how for long decades or centuries one service in a community could operate entirely independently of another because it dealt with superficial expressions rather than underlying deficiencies in the community. The social worker is strengthened by his understanding that, if community services are not harmonized, it is because they have not been attuned to the needs of those who are served, for the family whose child is in school or in court or in a hospital is still the same family. Behind this concept will also be a recognition that where community services are not harmonized, confusion of the patient or client or pupil almost inevitably results, for if professional workers have been unable to achieve a reconciliation of their services, it is too much to expect that the bewildered people whom they serve will be able to do it.

And so it is one of the essential opportunities of the social worker, if not one of his obligations, to see that the community services are tied together like a strong chain forged of good links. If one of these links proves to be poor in quality, it is not the duty of the social worker to close his eyes and mouth in respectful silence, but rather to be skillfully aggressive about it, for the quality of his own work is dependent upon the integrity of the whole chain. Of any agency, he may well ask himself, Is the staff adequately trained to do the job at hand? If it is a clinic, are the psychiatrists, the psychologists, and the psychiatric social workers up to the standards set for those fields?

The social worker knows how to get such information. Many others in the community will not know how. The social worker gets the evidence of poor clinic service if, for example, the report of the clinic is a mere repetition of information that he already has about the case; or if there is frequent failure on the part of clients to continue on the rolls of the clinic after the first visit or two, or failure on the part of the clinic to plan jointly with the social worker and others in the community whenever other agencies are involved with the same problem; or, if it is a visiting clinic, if it has no local tie such as an advisory committee.

Even better than the correction of a deficiency in a clinical service once it is established is the provision of leadership by the social worker in the prevention of missteps by the community while the clinic is being promoted. This is especially important at the present time because the shortage of personnel is leading many communities to consider the appointment of unqualified personnel. Some communities are setting up budgets that at best could not attract high-quality staff. When a clinic of good quality is not feasible, the social worker can turn the vision of the community into other directions that will still be constructive and lead to continuous development.

Because the chain of services is no stronger that its weakest link, the best clinic functions with low efficiency when it is set in a community whose other agencies are of low quality, and many steps may be taken toward the rounding out of mental-hygiene services in a community through other agencies before a clinic is started without imposing upon those agencies a psychiatric function. Merely reaching for the quality demanded by leaders in the field of education, health, and other professional areas gives broad opportunity for the advancement of mental-health services, pending the establishment of a clinic. Poor links in the community chain should not be used simply to fill a gap in that chain.

A study of the various fields of community health and welfare services shows that certain functions bearing heavily on mental health are to be found in the daily activities of the teacher, the doctor, the public-health nurse, the social worker, the supervisor in industry, the clergyman, and others, and yet it is the social worker alone whose training has included serious preparation for these functions. I shall refer specifically to four of them.

First of all there is talking with people. Call it counseling or interviewing or what you will. Talking with people is the most generally employed technical instrument of these professional groups, and yet it is the least provided for in professional preparation outside of the field of social service. This fact itself may seem to imply that talking with people is the peculiar responsibility of the social worker. If the social worker thinks this is so, he will continue to do an

unusually good job of interviewing, but the teacher in talking with parents, the doctor in talking with a patient and his family, the minister of religion in talking with his parishioners, and the public-health nurse, may, with the exception of a few intuitive souls, be making cases for the social worker.

Again, all of these groups are confronted daily, in almost every case, with anxiety. It is anxiety that brings people to them. It is anxiety that makes people leave them. It is anxiety that makes people misunderstand them. And it may be anxiety well understood and handled that can lead to a solution of their problems. But a thorough knowledge of anxiety, how to recognize it and its effects and how to turn it to advantage, has no organized place in the training of any of these professional workers. Still, the social worker is perhaps a little more conscious of it than the rest, and while turning this knowledge toward the improvement of his own formal training, is in a position to do the same for others.

The social worker is perhaps more completely focused on the family dynamics than any other group and is aware of methods of affecting in constructive ways the relationships between members of the family. He knows how such relationships influence human growth and development and human effectiveness. And here, again, every one of the other professions involved in community activity runs headlong into families, their tangles, their breakdowns, and their successes. And so, along with counseling and dealing with anxiety, the social worker has also the opportunity to help fill the gaps in the professional training of other workers in the community and to bring understanding to bear to eliminate those gaps in the professional schools.

In a fourth area of function that confronts all of these fields, the social worker has exceptional preparation for leadership. The teacher deals with children whose families are in contact with all sorts of community agencies, as are the doctor, the clergyman, the lawyer, the nurse, but an understanding of these agencies is not a part of their training. It is not without significance that those who are occupied with community organization come for the most part from the field of social work and not from these other fields. The social worker's life will be more livable and effective when

the social agency is used properly by these other functionaries in the community and when the mental health of people is less threatened by the confusion resulting from the failure of other professions to know how to use the community agencies and how to help people to get service from them.

Because the social worker is more broadly oriented to the needs and problems of others and the elements that enter into group living, he has the foundation for an appreciation of citizenship. He can function as an especially competent citizen because he has the orientation of social work. He may well forget for a moment that he is a professional and take part as an especially informed citizen in many community activities. He can demonstrate to the community generally what the functions of a citizen are and how others may take responsibility accordingly. He may ally himself with his local mental-hygiene organization. He may see an identity between his principles as a social worker in which respect for the individual is paramount, the principles of mental hygiene in which respect for the individual is paramount, and the principle of democracy which places sovereignty in the individual.

He will encounter many different kinds of effort to solve community problems. Some of these will by-pass this principle of the importance of the individual and perhaps even be successful, in a way, in solving some of society's problems by neutralizing the individual and allowing him to function at a lower level. But the social worker will not tolerate such a solution. He has before him at all times the task of avoiding such a compromise and seeking solutions that, though more difficult, tend to preserve the value placed upon the person.

It may take some breadth of perspective and special clarity of thinking at times to distinguish between functions that are peculiarly professional and functions that can be drawn out of the public generally. There are those of lesser vision who would throw the volunteer back to the kitchen sink and the bridge table. There are others who see in the volunteer not only an aid technically, even though at times a nuisance, but a means of enhancing public understanding and achieving a level of citizen responsibility which, in the final essence, is

what the community agencies depend upon for their sanction and support.

The social worker, by virtue of his high educational requirements and professional training developed in recent decades without the drag of too much tradition, is in a favored position to provide the kind of leadership and support that I have visualized and in fact often observed. I am confident that his potentialities will in the decades to come develop community conditions that will be much more conducive to mental health.

THE PROFESSIONAL PERSON — A MENTAL-HYGIENE RESOURCE *

IN MEDICINE

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THE modern physician who is qualified for specialized practice has been characterized as some one who knows more and more about less and less. His field of interest and competency has tended to be limited to certain zones or organ systems of the human body. All too often he seems to forget about the living, acting, feeling, experiencing person who is his patient and who harbors sick organs for which he is consulted.

This overemphasis on specialization has led to an interest, on the part of the medical profession and the lay public alike, in encouraging more young physicians to go into general practice and recreate the old-fashioned "family physician" as an integral part of community life. The virtues of the family doctor have perhaps been over-glamorized, but there is no doubt that, with his knowledge of his patients, their families, and their social and community relationships, he was in an extremely favorable position to help them as people. He was able, through his knowledge of people and his respected position, to give wise counsel and to be an important factor in the mental health of the community.

The criticisms addressed to overspecialized medical practice do not hold for the practice of pediatrics. This specialty is a specialty of general practice in the age period of childhood. It is not limited to an interest in sick children. The pediatrician is the only medical practitioner who spends a great deal of his time in dealing with physically well patients and in attempting to keep them so. The concept of the physician rushing from one sick bed to another does not

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apply to most pediatricians. One successful pediatrician in a New York suburb tells me that in ten years of practice he has seen only a half-dozen children sick enough to be hospitalized.

It might be well to describe in a little more detail the manner of modern private pediatric practice in most communities. After the baby is born, he is taken to the pediatrician at frequent intervals for periodic check-ups. These so-called "well-baby" visits may first be at monthly intervals and then less frequently during the first three years. After this most pediatricians like to see their child patients once or twice a year.

Thus the parent, usually the mother, brings her baby frequently during what are usually called the "formative years." She expects, and the pediatrician is able to give, advice on feeding, sleeping, toilet training, disciplinary measures, and other things. She looks to him as an expert on child care, and if not too emotionally involved herself, is able to act on his suggestions. The pediatrician is expected to know a great deal about mental, social, and emotional growth and development as well as the physical aspects of growth. Many of the questions that he is asked have to do with the more psychological aspects of the young child's life—over 50 per cent, according to some practitioners.

It is obvious that the pediatrician is in a peculiarly strategic position with regard to the mental health of childhood. He sees the child and parent frequently and is looked to for advice and guidance about the total child. Modern psychiatric thought is agreed that a good state of childhood mental health is dependent upon a satisfactory emotional atmosphere in the home which satisfies the child's basic psychological needs and is related to emotionally healthy parental attitudes. The young infant's psychological needs cannot be separated from his physical needs—adequate food, warmth, shelter, mothering. The pediatrician enters directly into the guidance of the infant's earliest relationship to the outside world—the feeding relationship with the mother, so important as a nucleus from which other interpersonal relationships develop and the child's personality gradually emerges. Concern not only with what the infant gets to eat, but with how he gets

it is a part of everyday pediatric practice. The psychological aspects of feeding arrangements are important in the mental hygiene of childhood and most pediatricians are aware of their opportunities and responsibilities in this area.

The pediatrician is also in a position to safeguard the child from unwise pressures and demands for levels of performance beyond his stage of development. The need of the child to grow and develop in all spheres at his own rate is a fundamental one. The pediatrician can attempt to influence parental attitudes and thus improve the emotional atmosphere of the home. This is not too difficult for him to do in most cases, but where one or the other parent or both are emotionally disturbed, the pediatrician's training has not given him the tools, nor does the nature of his practice give him the time, to help in changing attitudes that are harmful to the child's mental welfare. The pediatrician, however, never deals with the child alone, but always with the parent-child unit, and he is often able to influence parent-child relationships for the benefit of the child.

One might say that the pediatrician described above is idealized and that many in practice now are not equipped by training or inclination to be too helpful in meeting the mental-health needs of their patients. This may be true in some communities, but pediatricians generally are aware of the job to be done; in fact, the community demands this type of service from them. The American Academy of Pediatrics, the national professional society of practicing pediatricians, is organizing a section on the mental-health aspects of pediatric practice. An anticipated function of this section is to provide postgraduate instruction in this area for those who did not have it in their training period.

Many of the hospitals that provide for resident training in pediatrics now have psychiatric liaison services whose principal mission is to provide a mental-health orientation for the pediatrician in training. The hospital to which I am attached has recently lengthened the period of basic training from eighteen months to two years, so that four months' full-time assignment to the psychiatric liaison service could be included in the training. This change was made because of the desire of the resident staff itself, and the

strong sentiment among the hospital graduates now in practice that such training was essential for meeting the needs of their patients.

One can feel reasonably sure that the capabilities of the pediatrician in the mental-health aspects of his practice and as a mental-health resource in the community will improve in the future. The pediatrician is aware of his opportunities and obligations and is anxious to become more adept in the promotion of mental health. He is often not aware of community social agencies and how they can be of help to his patients and their families, and to him in his practice of "comprehensive pediatrics." At the Babies Hospital in New York City, we know that he can work in collaboration with the social worker. I am sure that, given the opportunity, he could do likewise elsewhere and in the community. It should not be too difficult for the social worker in the community to bring to the pediatrician an awareness of her function wherever she is. Many pediatricians devote some time to community service, in schools, well-baby clinics, and elsewhere, and are accessible.

IN NURSING

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NURSES both in hospitals and in public health are in a singularly advantageous position for making a valuable contribution to mental hygiene. Theirs is a service needed and sought in times of stress and illness when the inner security of the individual is disturbed. The nurse can do much to reëstablish this security by her approach to the patient.

The rôle of the nurse is quite clearly defined in the minds of most people, but her responsibility as a health teacher is not so fully accepted within or outside of the profession. In the past, emphasis in her training has been placed on skills in the recognition and treatment of physical illness under

the doctor's direction. Her part as the person who gives physical care remains. With the growing knowledge of the relationship between mental, emotional, and physical health, these skills are inadequate. The basic training includes psychology and psychiatry, but tends to stress the serious deviations from normal that require institutional care. The nurse's training must include knowledge of the normal ranges of personality change to be expected during illness.

The nurse has close contact with the hospitalized patient over long periods of time and under conditions that promote confidence. She can encourage the patient to express his anxieties, so that worrisome misconceptions may be cleared up. Her observations are a source of invaluable help to the physician, the psychiatrist, or the social worker. She is part of a team, all of whom have the same aim—the patient's recovery. For example, a guidance clinic would not work with the child alone; the family and the school would be informed of plans. The nurse's position is somewhat that of the family, since she has the longest contact with the patient in the matter of time.

A recent study by the Children's Bureau in a local pediatric hospital shows that the emotional needs of the child and the parent are inadequately met during illness. This is due in part to pressure of work and shortage of personnel, but it is also due partly to the nurse's lack of understanding of normal growth and development. This is not a fault of nurses alone, but rather that of our educational system. There is a tendency to stress factual content and to lose sight of the individual to whom this content is to be applied. Illness and separation from the home are difficult experiences under the best of circumstances. The nurse who understands the normal development of the child wins his coöperation, makes his hospital experience a happier one, and speeds recovery. The visiting hours are an excellent opportunity to talk with the parent about the child's adjustment to the hospital. It is an opportunity for the nurse to broaden her understanding of the individual child, so that she may give better care.

Physicians and hospital authorities must work with the nurse to make hospital routine more flexible. Intelligent,

sympathetic care is essential for all patients, but lack of it is a real handicap for the child who has a long-term illness such as rheumatic fever or an orthopedic difficulty that will require repeated hospitalization or convalescent care. The nurse, because she is the substitute mother person for the child for such long periods, must give to the child the same warmth and sense of security that he normally gets from his mother if he is to recover from his physical condition without emotional damage. Long-term illness or restricted activity are difficult to accept realistically. The nurse can help parents and children with this, so that future anxiety may be avoided. The parents must be kept in the picture, probably make active contributions to the care, if the child is to make a happy transfer from institutional to home care.

The public-health nurse's rôle is perhaps less understood by both the professional and the lay public, yet hers is a vital contribution if mental health is to make progress. Her function is health guidance to the family. The public-health nurse sees the family as a unit in their normal background. Her contacts with the family extend over long periods of time, so that she is in a position to understand and to evaluate relationships. Most families, too, request the services of the public-health nurse; her help is something that they are seeking. She holds a key position both in urban and in rural communities. She has a working relationship with all the organizations interested in health and welfare. She knows her people and their problems. Hers is the greatest opportunity for case finding and follow-up for others working in the field of preventive mental hygiene.

The rôle of the public-health nurse in maternity and child care is fairly well known. The publicized aim of this program was early and continuous care for mothers and early and continuous health supervision for children. Statistics show that the public is fairly well educated as to this need, and in the minds of many, the public-health nurse has reached her goal. This, however, is not true. Few physicians have or take the time to allow mothers to talk about their normal conflicts and fears, and many mothers feel that these worries are not worthy of the attention of a busy physician. Unanswered questions and worries add an unnecessary burden to

the prenatal period. Misinformation and fears are an added hazard to delivery. The public-health nurse, with her knowledge of physical needs and accepting her rôle as a health teacher, can do much to allay the normal fears of pregnancy through classes and individual conferences with prospective parents.

It is accepted in most circles that a child who comes into a hostile or an insecure home environment will soon show effects of this atmosphere. The mother who has been given an understanding of what her baby is like, what to expect normally, is less fearful and more likely to create a favorable environment for the newborn.

A physician may be pressed for time and have little opportunity to discuss the child's development or the mother's problems, even though the child may be under his continuous care. The nurse does not assume the responsibility for health supervision, but she is an invaluable aid in supplementing the physician's supervision. Immunizations and other treatments carried on in the doctor's office or the clinic may be a traumatic experience both for the child and for his parents. The nurse, by explaining the situation, may allay fears and make continuous supervision more certain.

The information she can give the mother about child development helps the mother to meet the individual needs of her child. The introduction to solid foods, weaning, toilet training may be real hazards in the emotional adjustment of the young child. The public-health nurse, with her basic knowledge of pediatrics and an additional knowledge of child development, may be a potent factor in the prevention of so-called behavior problems in the preschool period. She is the family health counselor who is in a position to help the family with their everyday problems. With her knowledge and resources for consultation, she can make a great contribution to mental health.

A new field is opening to the public-health nurse with the problems associated with an aging population. Our understanding of the total needs of the individual, emotional, social, and physical, have developed to such a point that all factors are being included in plans for the care of the aged. With short hospitalization and convalescence at home, the nurse

must be able to give not only skilled nursing care, but understanding guidance to the family.

It has been pointed out that the nurse's training does not include adequate preparation in the preventive aspects of mental health. She may feel that she cannot contribute largely to a mental-health program. It is a matter of understanding her rôle. For in spite of inadequate training *per se*, the nurse is practicing good mental hygiene if she is successful in her job. For example, recently a nurse physiotherapist was requested to visit a patient and give treatments to reduce contracture. This woman's fractured leg was completely healed, but she was not walking. After several visits the nurse learned that the woman's husband had died just before her accident. The patient felt that there was no reason for going on, and staying in bed was her way of escaping. The coöperation of the physician and the social worker is needed here, but the nurse's rôle in the team is clearly indicated.

Both in the hospital and in public health, the nurse, when properly trained and fully aware of her responsibility, can recognize and apply corrective measures to minor mental problems. Accepting her responsibility, she will recognize and refer to the physician's attention the more difficult problems. The nurse is a key person in the program for mental health. She needs added knowledge and consultation service. These services, we hope, will be made available to her.

IN SOCIAL WORK

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REGARDLESS of the particular area in which she works, every social worker knows from daily experience that her work contributes to the prevention of unnecessary anxiety and hardship, which in themselves can break a person's emotional strength. Whether the crises of our clients are potential or actual, we know that our services can prevent mental breakdown, delinquency, and crime. We know this, too, whether we are in direct contact with clients, or are the fund

raisers, the community organizers, the administrators, the supervisors, and so on. However, it is good to pause, now and then, to take stock not only of what we contribute to any community's mental health, but also to see our service in relation to other professions.

What is it that we do that acts as a mental-health resource for individuals? First, there are the actual services we offer: a foster home for a man's motherless children, financial assistance to a deserted wife and her family, a place in an institution for an aged person, counseling for people troubled over their marital relationships, settlement-house activities for adolescents in delinquent neighborhoods, and many more. These services, provided through government and private resources, are the means whereby a person can meet an immediate problem, can be freed from unnecessary hardship and anxiety—freed to carry on independently. They are important bulwarks against delinquency, crime, and mental ill health.

We talk often, however, of the fact that in and of themselves these services are not necessarily constructive. We say that the way in which they are given is more important. From what does this certainty stem?

Through the years, and often in bitter experience, we have learned that the client's crisis lies in two areas. He has an immediate problem that must be met. He has also a less apparent, but equally important crisis in the state of mind with which he comes for help.

"How did I ever get into this mess?" is what we often hear, and more often see, beneath his behavior. "I've tried every way I could think of to help myself, and I'm only going around in circles. Other people seem to manage all right. Why can't I? Am I so different, so inadequate? Or is it just hard luck?"

Beneath these questions lie the beginnings of a person's doubts of himself. How much can he trust his judgment, how much is he entitled to the respect of others? This is fallow ground for mental ill health. For mental health, one has to be able to feel secure in one's ability to manage within the realistic limits of the outside world at any time. One has to

have a sense of one's own worth. To find one's self in need of help—for a large or a small matter—can be destructive of confidence in one's judgment and self-respect.

How we meet the client, then, and how we help him at this time, may have an important effect upon his future state of mind. This influence begins with the administrative set-up, the policies, the procedures under which we offer our services. It continues through supervision to the direct interview with the client.

For example, in a relief organization, do we offer financial assistance to citizens who have a right to this help under certain conditions? Or do we offer it to inadequate persons who are inclined to cheat unless carefully watched, and whom we do not believe until they prove themselves innocent? In a child-placement agency, do we offer a man a foster home for his motherless children in a way that permits (or enables) him to be their father? Or do we plan for the children without regard to him, and treat him as a necessary nuisance on visiting days? In a child-guidance agency, do we recognize the parent's desire to help his child as expressed in his act of bringing the child to us? Or do we see only how he created the child's problem or how he complicates our work?

In any of these situations, and many others, just in the attitude with which we greet our clients, there exists the possibility of deepening a person's doubts of himself, thus adding to the emotional stress with which he comes in. Depending upon how we meet him, we can help an adequate person deal with a difficult situation. We can provide the opportunity for a less adequate person to begin to deal with his problems more satisfactorily. This opportunity lies at the very outset of the contact in the policies and procedures that set the tone of the individual interviews.

In the actual interview with the client, do we help him evaluate how he got into this crisis that calls for help? To what extent was it due to uncontrollable outside factors? To what extent did he himself create the trouble? Do we help him to think problems through, and to be able to trust his judgment? When a person comes to us in great anxiety and concern, he often wants us to take over for him, to

decide what should be done. Out of a desire to alleviate the present pain, to end suffering quickly, we may want to do as he asks. It takes skill and professional discipline to help the client evaluate to what extent this is necessary. We could err, and take over too much, thus only strengthening his fears of his own ability to act in his own behalf. We could do too little, leaving him with more than he can carry, adding only to his feeling of inadequacy.

Our contribution, then, is not alone in the services we offer, but also in the knowledge we have acquired about what can make a crisis a constructive rather than a destructive experience. As we apply this knowledge in every facet of our service, we develop resources for mental health. A person who has once handled a crisis well, and used the help of others as he might his own resources, is a person fortified for other crises life may bring. In that sense alone, he is already a stronger person emotionally.

There is another way in which we, in our daily work, can act as a mental-health resource. This is in recognition of, and respect for, the skills of other professions and their relation to mental health.

To make this point clearer, let us take a case—more composite than mythical: An eighteen-year-old girl, one of a large family. Her parents are self-respecting people who meant well by all their children. This girl was one of so many that she was emotionally deprived, needing more attention and affection than she could get. She was a good child, pleasant, obedient, affectionate. She met a man who showered her with attention, provided her with what she felt to be true love. At the time when she found herself pregnant, she accidentally discovered that he was already married.

What are some of the questions such a girl may have as she arrives at a social agency for help? She certainly will be wondering how she could have made such an error. She certainly will be questioning her own judgment, her ability to plan for herself. Aside from this, she may be thinking, "Will I live through childbirth? What must I do to be sure my child will be born healthy?" These questions are full of an anxiety that only medical care will alleviate.

She may be thinking, "Shall I give my child up in adoption? Will he be better off with me? If I keep him, how will I support him? What if his father refuses to support him, is there a law to make him do it?" These questions may involve legal assistance. The anxiety beneath them is equally destructive of mental health.

She may have strong religious ties. Questions of her salvation and that of the child may be extremely disturbing. Reassurance from us will not help. She will need her minister to help her achieve some peace of mind.

There is danger of misunderstanding the true nature of the problem. For example, we might say, "These questions she has are merely psychological projections of her indecision about keeping her child or guilt over what she did to her parents. When I have helped her determine her real desires, questions of her health, her child's, her means of support, or her salvation, will solve themselves." In some instances this may be true, but in most instances it is dangerous to assume this. The longer we postpone this girl's going for help to a doctor, a lawyer, a nurse, a minister, or an educator, the longer she will have to endure her anxiety and the more difficult it will be to keep her in sound mental health.

In the space available here, it has been difficult to do more than introduce a few generalities. Nor has it been possible to touch on all the areas in which, as professional people, we contribute a mental-health resource. I have confined myself to one area of our professional life: that of practitioners in the broadest sense, as persons administering or offering services already provided by government or communities. I have done so deliberately. The words, "mental health resource," are so awe-inspiring that I feared we would look for new and fancy ways of meeting the responsibilities inherent in these words. I wanted to emphasize that in our daily—and what at times seem very mundane—duties, there exists an opportunity to help keep our nation well. I wanted to emphasize that regardless of the kind of service we offer, or what our part is in offering this service, we are either psychiatric social workers in the truest sense of the word or we are not social workers at all.

IN EDUCATION

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EACH of the professions concerned with human welfare has, of necessity, been so much concerned with its own methodology, with its own problems and their cutting edges, that it has been difficult to keep up with what other professions may have to contribute to its field. It is difficult for us to see the necessity for teamwork in the life of a child. There has been an honest striving on our part to be better teachers, better doctors, better social workers, and better clergymen, but if we look around our communities, particularly our larger ones, I wonder if we will not find that what we have done to the child is to make him at one time a patient, at another time a client, at another time a worshiper, and at another time a pupil, and I wonder if the child is "fractionated" into these different personalities in these different rôles.

I wonder further if one of our great challenges to-day is not that of realizing that this little pupil, patient, client, or worshiper is a person—all one person—and that the faster we can get together and work with him as one person, the more progress we will make. I wonder if this does not mean that we have to create ways of developing more and more case conferences around our boys and girls in which all of us participate.

I know you are thinking, as I am, where is that extra day between Sunday and Monday that we can devote to all of these additional tasks? Well, if we have effective teamwork, we would save time in the end by putting it at the beginning, because each of us then could multiply his own contribution by the strength he would get from teaming up with the other workers who have so much to offer. In other words, I think we really have to crash through our professional party lines and recognize that our common goal is the welfare of the child, his best growth and development. If that is our common goal, then eventually we can learn to speak a common language. Although my chore is to talk about the teacher in this mental-hygiene program, I want you to put

between the lines of everything I say that the teacher is a member of this team, and cannot act alone.

It is true that we teachers do have a peculiar responsibility in the mental-hygiene field, and it grows largely out of a statistical reason: sooner or later practically every child has a teacher. Sooner or later some teacher sees almost every child. Therefore, our responsibility in detecting and preventing difficulties is really very great, and I share with our public-health nurse the concern that our training is not adequate.

We teachers spend a great deal of our time getting ready to teach the three R's. The reason is that the public makes a terrific demand upon us to do so; therefore, you cannot help but have professional training schools that respond to these public pressures, which are placed squarely in the wrong place.

Our teachers' colleges now are trying very hard to place more and more stress upon training in child development, in mental hygiene, in basic psychiatric concepts. And I beg you to help us convince our communities of the importance of this.

The prevention and the detection of difficulties could each be the subject of another long conference. All we can do now is indicate a few of the areas in which teachers are trying to learn how to be sensitive. We are learning more and more of the important symptoms of difficulty. If the Wickman study[1] were being made to-day, I think it would be very different. You remember what came out of that. Parents and teachers were primarily concerned about the aggressive pupil who "busted up" the routine, made a mess of things, and got in the way. The shy, retiring little fellow who did not bother anybody was O.K., yet he might have been the sickest person in the whole group. I am glad to report that we are beginning to know it, and we are beginning to act on it more and more as teachers. More and more as we get released from the old strait-jackets of educational tradition we are learning that the active and alert children

[1] See *Children's Behavior and Teachers' Attitudes*, by E. K. Wickman. New York: The Commonwealth Fund, 1928.

may be a great deal the healthier, and we are beginning to approve of that kind of child instead of suppressing him and worrying too much about him.

The teacher and the administrator in the modern school now also realize how important it is for parents to get honest-to-goodness, sympathetic help.

There are still many schools in which when the parent darkens the door, the teacher is prone to say to herself, "What have I done?" and when the teacher moves toward the parent or visits the home, the parent immediately gets terrified and cries, "What has Johnnie done now?" We are working very hard to break down that negative relationship. We are trying to do it by saying to ourselves, "Wasn't this an awfully nice thing that Johnnie did! Let us communicate with his parents about it so they will know, too." We are in effect saying to parents, "Look, your teacher needs to be appreciated. She is having a hard time making ends meet. She is worried to death about a million things."

Let us never forget that parents and teachers are human beings, with human frailties, with anxieties and difficulties. I think all of us, in the professional field particularly, should take a sort of pledge every year to remember under how much pressure parents now live. If, as I said before, the child is "fractionated" into so many professional areas, how must the parent feel about the conflicting advice he gets from all of us? Or if it is not conflicting, let us admit that it is often so obscure, and the language so difficult to understand, that the parent really goes away confused and bothered by our sincere effort to help.

We know, too, that every time the child comes to school with a problem, that problem has a past, and a past that nine times out of ten is connected with his parents. We as teachers want your help in learning more effectively how to work with parents. We went through a period when we thought that we ought to tell parents everything. Then we found that we were really hurting children; we were "bolloxing" up situations; we were adding more disturbance to an already disturbed picture. Now we are beginning to realize that parents have to develop readiness for insights, for understanding, and for revelations, if you please, about their

children; and that we have to be as concerned about that readiness of the parent as about the child's readiness for any kind of learning. We need help with that understanding, but we are trying very hard to get it. We are trying to realize that blaming parents gets us exactly nowhere; as a matter of fact, it probably puts us back.

If the teacher's goal is to persuade the parent of a child who is having difficulty to seek and to accept the expert guidance that other professions have to offer, then we must learn enough of the psychological approach to the parent to get him to want to accept the help that we think is needed. That is one of our toughest problems. Even teachers who have really tried hard to learn how to do this are constantly meeting parents who feel so guilty and so upset that it is difficult to persuade them that help is really necessary. I have found myself again and again in all humility, after having made hundreds and hundreds of mistakes, able to say to a parent, "I need help in understanding what to do for this child. I wonder if you need help, too," and by putting myself first as the person who needs help, I have often been able to get parents to be more willing to accept it.

I wonder if it does not indicate the need, on the part of all of us who are trying to steer people in the direction of the help they should have, of a great deal more humility than we sometimes exercise. Here is where teamwork is so important, because unless the physician, the nurse, the social worker, the clergyman, the lawyer, and the teacher work together, we will achieve very little. Unless they work with sympathy, unless they work quietly, and unless they work lovingly with the parent, they will have the parent all ready for help, and then six months later, the matter having gone up through a hierarchy and down through a hierarchy, comes a report from a child-guidance clinic or worker couched in language that neither the teacher nor the parent can understand or knows how to apply to the situation in question.

Let us be honest. Let us try to tackle this problem. I teach teachers all the time, and in our discussions we say, "All right, we are getting this insight. We know the particular child's needs. We know this child needs help. We refer this child to help. We refer it to the assistant prin-

cipal; the assistant principal refers it to the principal; the principal refers it to the district superintendent; the district superintendent refers it to his child-guidance bureau; the child-guidance bureau puts it on its docket. Then after a while down it comes the reverse way. Down comes this material."

Maybe that is unfair. Let me say right away that I think it is unfair, but it illustrates a very real and serious problem in teamwork which we have got to solve, because when we get the parent ready, and when the teacher—who is new in this field, relatively speaking—is ready, then we have got to have the other services also ready to step in and join hands and do the job. There, again, is where the case-conference approach is vitally necessary.

You see the teacher often feels left out, feels inferior. Perhaps we teachers have brought that on ourselves. Perhaps we are inferior, but you won't get us to be any better by making us think that we are. You see, we don't know the lingo of the psychiatrist. We don't know the lingo of the psychiatric social worker. We do, however, spend five or six hours a day five days a week with the stuff of life, the children, so you had better use us, and learn to speak a common language with us, and not make us feel, as so many teachers do, that they are sort of pushed over to one side as a group that really does not know and does not understand.

I find that particularly true of teachers in institutions. If the pediatrician, busy as he is, if the surgeon, busy as he is, if the occupational therapist, or particularly the physiotherapist, wants that child, that child goes, and the teacher may be left standing. I visited an institution once where a teacher was working at a child's bedside, and I heard the doctor in charge say, "Stop that noise over there?" It was just the teacher teaching the child.

Again, perhaps I am exaggerating. I don't mean to. But we do feel rather like newcomers, and we do feel sometimes as if we had our foot only halfway in the door.

Now as to the other question, the teacher's rôle in building for positive mental health, that, too, is a subject for another whole meeting, so we cannot go into any great detail on that here and now. The word "positive" is the key. In the old school, teachers tried to find out what a child could

not do and then kept him doing it all day. If he could not spell, he got extra spelling. If he could not read, he got extra reading. If he could not do arithmetic, he got extra arithmetic. Imagine what it felt like, leaving home in the morning knowing that you were going to spend most of the day in doing what you could not do. That to me is the worst mental hygiene in the world, and we are trying, and I think successfully, to change that old attitude. We are now saying, "All right, let us use the same ingenuity in finding the child's strengths. Where do his strengths lie? What are his vital interests? Where is he going? Where is his energy taking him?" After we get the answer to those questions, we say, "Let us hook onto those. Let us go along with him." And oddly enough, if you do that, the reading, the writing, and the arithmetic will come right along too, and you still have the powerful positive motivation of working on a child's basic positive interests.

We know now, too, as teachers, a great deal more than we did before about how to reject a child's behavior without rejecting the child. I need not enlarge on that here, but I am very glad to report that more and more teachers understand that a perfectly worthy person has to make a lot of mistakes before he grows up, and that dealing with mistakes in a way that still leaves the person worthy is one of the great challenges to the teacher.

Also, we know very well that children learn more from one another than they ever learn from teachers, and we are beginning to be more and more concerned about how to compose groups, how to put children together in living groups, so that out of that living group they learn this other dimension of democracy, this other dimension of growth, which can come only through living with your peers—living well with your peers—and learning through experience the problems of living in a group. We are more and more suspicious, therefore, of artificial segregations, of putting high I.Q.'s off together, and low I.Q.'s off together, putting problem children off together, because our hunch is that they will come out bigger problems as a result. Group living ought to provide a microcosm of democracy. It ought to give a child the opportunity to learn to live and to grow in an environment in which he lives with all the kinds of people with whom he is later going to live and grow.

IN THE MINISTRY

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IN each of the excellent preceding papers, there has been implicit a proposition that could be stated something like this: The professional person in the community is a mental-health resource if he meets certain conditions. These conditions, of course, have to do with his training and with his attitudes. I take it we are not primarily concerned here with the training of the professional person, but I think a word should be said about his attitudes.

It seems to me that the helpfulness of the professional person in the mental-hygiene program depends upon three general principles. The first is this: the professional person should have a deep reverence for the integrity of the individual with whom he is working. It has been obvious, from each of the preceding papers, that there are ways in which the professional person, with the best intentions in the world, can be guilty of malpractice on human minds and souls. Usually it is in the form of attempting to manipulate the individual, to do something for him, to superimpose something upon him. If we have real reverence for the integrity of the individual, it sometimes means that we are willing to listen to him. That is a terrible sacrifice for a parson. We are trained to pray or to preach at the drop of the hat, and to remain silent and listen to our parishioners is a very difficult thing to do, but it is a sacrifice that we simply have to make.

The second principle that I find implicit in each of the preceding papers is that the forces and the resources in the situation with which we are dealing can be trusted. This is a matter of faith: that in the client, in the penitent, in the patient, there are elements that can be trusted, that growth is possible. And this is particularly true in the case of children, in the family situation.

This matter of faith I think is very important for the professional person. Too often we professional folk have said, "There is nothing we can do," or, "The thing can only be done by forcing some plan upon the individual."

In the third place, in order to be really creative in a mental-

hygiene sense, the professional person needs more understanding. He needs constantly to be asking himself, "What does this situation really mean?" We are too prone to tag behavior or to make categories. This man behaves as he does because he has red hair, or because he is an Episcopalian, or because his forebears were Irish. That is not enough. We need to take each individual separately and attempt to understand him.

Here, then, we have reverence and faith and understanding as necessary in each of our professions where we are dealing with individuals. We all have wonderful opportunities—there is no question about that—but do we make the most of them? Consider the parson, for example. Think of the many different contacts and opportunities which we have that may prove to be helpful to individuals. We are at the beginning of the developmental line in that we have something to do with the family and with the child when he is born. We arrange about his baptism. We give instruction to the parents, to the godparents, and to others. We touch the life of the growing child because we are responsible for his religious education which begins very early. Often, you will remember, children go to the church school or to the parochial school a year or two before they enter the public school. We prepare the child for his first communion or for his confirmation at a very important period in his life, sometimes just before adolescence and sometimes during adolescence. We give premarital counsel to the couple before they are married, establishing a rapport that makes it easy for them to come back and talk over their difficulties, if difficulties arise in marriage. As a matter of course, we visit the sick. As a matter of course, we are with the dying and we give counsel to the bereaved. All through the developing life of the individual we have opportunities at these nodal points. But we need to have the reverence, the faith, and the understanding of which I have just spoken.

In closing may I say also that the clergy have a number of resources in their gift which, I think, make for mental health. Worship is a group experience. The theology that we can offer people as answers to the eternal questions makes for security and the understanding of self and of others. There

are also certain resources in the gift of religion that can be used in times of stress both by the growing individual and by the mature individual, such as the sacraments and the rites and ministrations of the church. We would differ among ourselves as to what these are, depending upon our own communion and religious orientation.

The clergyman has wonderful opportunities, as does every other professional person, for helping people in time of stress, for helping people grow. But, let me repeat, this help can be given only if we ourselves have these essentials: reverence for the integrity of the individual, faith in the curative process, faith in the developmental process, faith in what people can do for themselves and in what God can do for them, and an understanding of the real experiences and the real emotions of the people with whom we deal.

IN THE LAW

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I CANNOT really pretend to talk about what my distinguished confrères have said excepting in the sense that any student feels free to criticize his teachers. So, by your leave, I am going to do two things: For just a moment, I am going to try to find something to say about a lawyer, and then I am going to try—and that will be a much easier task, I assure you—to say just a little bit about what I have learned from the preceding papers.

There are a few ways in which a lawyer or lawyers can help with the problems that we have been discussing here. The lawyer is not in the same situation as many other professional persons. By that I mean that he does not have continuous and repeated contacts with his clients, as the teacher, or the physician, or the social worker, or the public-health nurse, or the clergyman has. His connection with problems in mental health is much more likely to be sporadic and occasional, but there do arise occasions when a lawyer

is faced with the same sorts of problem that these other professions have to deal with, and sometimes, with the assistance of these other professions, perhaps he can in effect be a resource in this field.

The most obvious kind of situation in which a lawyer encounters these problems is when he is consulted about marital difficulties. I don't suppose there is any field of law in which the personalities and personal problems of people come to the fore as they do in situations of that sort. I think statistics would probably show that in well over 99 per cent of such cases emotional disturbances are present in one or both of the parties, and I think a lawyer who recognizes that, in addition to being a lawyer, he is a human being, can at times render yeoman's service in straightening out personal difficulties, whether the eventual outcome of that particular situation is a divorce or a reconciliation.

Or again, where there are disputes over the custody of children, even where there are disputes over what is left behind by the departed, a lawyer, just by being a decent human being and acting like a human being instead of like a lawyer, can help to resolve people's difficulties.

There is one concession that I think you will have to make to the attorney, and that is that his duty to his client sometimes interferes with his doing and saying all of the things that he might do and say if he were a free agent. After all, a client does not go to the lawyer ordinarily as he would go to the psychiatrist or to the clergy. He goes to him for specific assistance and not for general advice. Quite often, however, the attorney's duty to his client is completely reconcilable with his duty to himself and to his community, and if you will forgive me for a moment, I will just sketch a few of such instances. I will take them from my own experience with the adolescent boy.

I may say, by the way, that in most cases a judge is also a lawyer, and I think the wide-awake social worker frequently has an opportunity to make use of the facilities that an intelligent judge affords. Don't ever try to manipulate a judge, but if you can do it, more power to you!

I remember one case, for example, that of a youngster, a boy of about seventeen, who was committing a series of bur-

glaries. As a matter of fact, he committed one while he was out on parole awaiting sentence. He posed quite a problem. He was lame. So instead of just sending him off to jail or patting him on the back and saying, "Be good," we did a little investigating. We found that his lameness had reached such a stage that he was going to lose his leg and probably his life unless something was done about it, so we had extended conferences with him and with his family. When I say "we," I take the credit, but of course the probation officer did the work. The net result was that we arranged for an amputation. That required conference with the proper public sources and with the hospital, and the leg was amputated.

Then we discovered by continuing study that he was thoroughly unhappy in his school work and uninterested in it. The ordinary academic work did not interest him, so we arranged for a transfer from the school that he was attending to a special crafts school, which required obtaining a scholarship for him. I think one of the most pleasant experiences I ever had personally was about two years after that when I discharged him from probation and saw in the flesh the demonstration of what a completely changed person that particular boy was.

I take that as an illustration because that required an intelligent and understanding probation officer—and a probation officer, as you know, is just a species of social worker—and it required also the coöperation of three or four different agencies. By using all of these facilities, we succeeded in developing a normal youngster, neither better nor worse than the average; from a defeated, disappointed, antisocial young man there emerged an apparently healthy, happy, useful citizen. That required coöperation by lawyers, social workers, hospital personnel, and so on.

Again—if I may bore you with another illustration of what I have in mind—a young man came into court on the complaint of his mother that he was impertinent and disobedient, he would pay no attention to her, and spent all of his time indoors, studying, was not normal, would not go out on the street and play, and a whole list of complaints.

With the coöperation of that young man's lawyer, we did a good deal of investigating, and we came to the conclusion that the primary trouble was with the mother. This conclusion was confirmed when, after we had had a long talk with the boy and sent him away happy, within a month the mother was back in court again, this time with the complaint that the boy never studied and was always out on the street playing.

Realizing her instability, we arranged for him to live somewhere else. Within a month or two his whole attitude toward life was changed, and his attitude toward his mother and hers toward him were changed also.

All this sounds very simple, and of course when you have seen a plan work, you know that it was the right plan, but situations of that sort require intelligent understanding on the part of the lawyer who happens to be sitting as the judge at the moment, the social worker or probation officer, the lawyer who is representing the youngster in court (if there is a lawyer in court representing him), and, in the particular case I have cited, the persons at the head of the residence in which we obtained a place for him to live.

I don't know that I am a big city lawyer, but I am a lawyer in a big city. I grew up in a smaller city, and I think I have a better conception than perhaps some native New Yorkers of the function and rôle that a lawyer can play in a smaller community. There, I think, you have far greater opportunity to make use of the lawyer's talents in aiding you than you may have in the larger city, because in the smaller community the lawyer knows the people, and the people know him. If the lawyer is a person of intelligence and character, he commands the respect of his fellow citizens, and either as a friendly adviser or as what I might term an authoritarian adviser, he can be of inestimable service and help in persuading a parent, or a boy, or a wife, or a husband to do the intelligent thing. Over and above that, apart from the specific aid that a lawyer may render as a mental-health resource, I think you should make use of him as a leader in the community.

After all, you need a great deal of community education,

and you need a great deal of acceptance of community responsibility. Such things don't just come out of the air because you wish for them. You get them, if you get them at all, because somebody works for them. If you catch your lawyers when they are young and train them in the right way, they can be wonderful tools in corralling the community resources and putting them to work to help you make it a better community from the standpoint of mental health.

BOOK REVIEWS

A PATTERN FOR HOSPITAL CARE. By Eli Ginzberg. (Final Report of the New York Hospital Study.) New York: Columbia University Press, 1949. 368 p.

This is a thoughtful medical, social, financial, and political presentation of the entire field of hospitalization. It should serve as a reference book for any group interested in the establishment of a general hospital, a tuberculosis hospital, or a hospital for mental patients.

The chapter on "The Rôle of Insurance" is particularly timely and it should be considered carefully by every physician and by every advocate of "state medicine." The entire section on "Long Term Illness," whether due to injury, tuberculosis, mental illness, or other causes, should be studied by social workers in the welfare group.

Of particular interest to the readers of MENTAL HYGIENE are the chapters, *State Hospitals for Mental Diseases* (note "Diseases" not "People") and *A Pattern for Psychiatric Care.*

Those who expect that an increase in the number of psychiatrists, social workers, psychologists, nurses, occupational therapists, and trained psychiatric attendants will solve the state-hospital problem should read the section on psychiatric care. Discussing an active therapeutic program and an increase in the number and quality of professional personnel, the report states: "An increase . . . would doubtless improve the therapeutic results. . . . Some patients who now fail to respond would do so. . . . But there is no basis for believing that the number would be so large as to alter significantly the scale of the problem—that is, the number of patients to be cared for in hospital beds."

The report goes on: "The time is long overdue for a careful scrutiny of the overoptimistic claims which have been placed before the public by reputable psychiatrists, some of whom have generalized their successful experience in the Armed Services where the major problem was presented by soldiers who suffered from neuroses or acute psychotic episodes."

The discussion of the rôle of community clinics and of psychiatric wards in general hospitals should be given careful consideration by psychiatric planners, no matter in what part of the country they are making their plans.

While it is not possible to agree with every one of the conclu-

sions, and while it seems unfortunate that a little more emphasis was not placed on the treatment possibilities of family care and on the possibility of using many people other than psychiatrists for psychiatric therapy, nevertheless the matter-of-fact tone of the report makes it a valuable document for any one interested in the problems of hospitalization. It has much more than a local value.

GEORGE H. PRESTON.

Fort Myers Beach, Florida.

PSYCHIATRY IN A TROUBLED WORLD. By William C. Menninger, M.D. New York: The Macmillan Company, 1948. 636 p.

Here is an outstandingly important and timely book. The purpose, as stated in the foreword, is "to record the evolution of psychiatric practice in the army . . . in the event of another emergency. The first part of the book was, therefore, written chiefly for the record . . . the second part . . . with the hope that it might be helpful to any person who has to get along with other people." Despite this somewhat paradoxical purpose—that of recording the recent war experience of psychiatry for application in the event of another conflict and also as an aid in the event that we are permitted to continue to live in a semblance of "peace"—Dr. Menninger offers a document of monumental value. Both in the first and in the second part, he explicitly exhorts psychiatry to apply more widely its training and experience to the problems that confront individuals, communities, nations, and the world.

Part I, *In War,* is divided into four sections. Section 1, *Background,* starts with a brief sketch of the status of psychiatry in the army prior to the recent armed conflict, and the deterioration of the position of psychiatric medicine in the army since World War I, with a special indictment of army medicine's rôle in contributing to this state. The next two portions of this section emphasize the initial handicaps and problems that faced psychiatry, which not only was totally unprepared, but, as is pointed out in strong, straightforward statements, was in no position to apply its experience from the previous world war. Interspersed in this background material are some optimistic statements that are forerunners of the later content.

The second section, aptly entitled, *The Soldier,* discusses the personality of the soldier and his environment, with its stresses, strains, and emergency supports. It is always difficult to know what the reaction of the non-veteran will be to a section like this, which, for one who has had army experience, brings home time and time again the many differences between what it means to live in a civilian community and what it is necessary for an individual to assimilate in order to become a soldier. The chapter dealing with the place of

women in the army will prove of undoubted interest to many who are unfamiliar with the facts and figures.

In the third section, *Clinical Observations,* there is an attempt to interweave some general theoretical considerations, rather as a guide for the lay reader than for the professional, with some of the particular problems that faced the psychiatrist in the army. Dr. Menninger's ability to relate theory to clinical practice, and to integrate both with the administrative considerations necessary for the practice of psychiatry in any organization with large administrative structures, army or civilian, reveals a degree of talent with which few in his profession are endowed. The discussions of malingering, homosexuality, and "the lowest 8 per cent" are particularly effective illustrations of his talents in this direction.

The fourth and last section of this first part, with the specific title, *Administration and the Practice of Army Psychiatry,* sketches the problems of administration in a more sharply defined way. From a different point of view, it brings home the need for relating the most incisive clinical skill to the development of administrative practice that will facilitate performance at the doctor-patient level. Here there is a discussion of the position of psychiatry, and of medicine generally, in the army that carries broad implications for the health of every citizen who is called upon to serve his country. For example, the author states that "although the Surgeon General nominally had the responsibility for the health of the army, his authority and function were clearly limited, even though in a case of a major calamity he certainly would have been blamed for any failure." It would seem that this in and of itself constitutes a major calamity which might well be the responsibility of every citizen.

The account of the development of the "Nomenclature in the Method of Recording Diagnoses" reveals how an appreciation of clinical factors can be adapted to facilitate administrative purposes, to create an effective instrument of interpretation of psychiatric therapy, and simultaneously to affect the quality of treatment.

Some of the chapters in this section might constitute dramatic revelations, as indeed will much of the material presented throughout the book, though the author's emphasis is clearly an attempt at a balanced presentation, with no little generosity in making allowance for some of the problems that might have been avoided had previous experience been utilized. The final chapter of this section attempts an interesting statistical comparison between World War I and World War II.

In Part II, *In Peace,* the author attempts to apply some of the knowledge gathered from army experience to our community problems. There is repeated reference to experience validated in the army

setting that is integrated with individual and community problems. In a preliminary chapter, Dr. Menninger discusses in popular fashion the maintenance of the mental health of "Everyman" and social reintegration and mental health in the home. In two hard-hitting chapters, he criticizes medical education and outlines a broader social responsibility for civilian psychiatry. In further chapters, he touches succinctly on psychiatry in relation to public health, academic education, criminology, and penology, as well as mental hygiene in industry and business. These chapters are a "must" reading for workers in these fields.

His final chapters concerning needed changes in the army include research needs and objectives in psychiatry, admonishment against "freezing to the past," and a restatement of the efforts needed to sustain the impetus provided military psychiatry by its experience in the recent armed conflict.

The appendix will prove of value, especially to those who are familiar with army psychiatry, since it gives a kaleidoscopic view of army regulations and other data. For other readers, the nomenclature and the material included from the army publication, *What the Soldier Thinks,* will be invaluable in giving an over-all picture of some army attitudes. The reference material in Appendix D will be most useful to administrators and individuals who need a handy list of references on military neuropsychiatric problems. The index, despite some minor errors, is well done.

In the effort to make his treatment comprehensive, the author probably covers more ground than should be included in one volume, and, because of this, much is dealt with in what might seem to be a cursory fashion. For example, the chapter on the contribution of psychiatry to public health covers but six pages. It may well be that this and other omissions can be rectified in a second edition, the printing of which is, we hope, assured.

In a number of chapters in which reference is made to the contribution of social workers, Dr. Menninger does not do justice to his own understanding of the content of the profession of social work. (He even likens it at one point to that of the X-ray technician.) In the paragraphs that he devotes to the subject of psychiatric social work, there is complimentary reference to this specific field of social work without mention as to how, specifically, it contributed. For example, in the chapter, *The People Who Did the Job,* one finds the comment that one of the best individual jobs of psychotherapy in the army was done in the mental-hygiene consultation services (mental-hygiene units), but no mention is made of the fact that it has been widely reported that the psychiatric social worker was the backbone of these units.

Dr. Menninger's tenure in the Surgeon General's Office dates from approximately two years after the start of the war, and it may be that some of his personal information is faulty up to that point. This has resulted in some notable omissions which, it is to be hoped, will be rectified in his second edition. The book nowhere mentions the American Association of Psychiatric Social Workers, whose efforts resulted in providing an office and employing a war-service secretary who proved extremely valuable to military psychiatry, especially before army directives could be drawn up and implemented through army channels. There is, again, no mention of individual psychiatrists, such as George S. Stevenson and Marion E. Kenworthy, whose activities with the war department, prior to and after the creation of the divisional status of psychiatry in the Surgeon General's Office, were an outstanding contribution; nor is there mention of such laymen as Eugene Meyer and Marshall Field, whose efforts in the aid of psychiatry were considerable. There is no reference to the editorials and feature stories in the *Washington Post*, which as early as July 17, 1942, called attention to psychiatric needs and the extent of the problem. Nor is there mention of the beginnings of direct mental-hygiene services to soldiers outside of hospitals as early as January, 1942, or of the efforts and support of individual army personnel, such as Brigadier General Edgar L. Clewell, U.S.A., whose pioneering efforts led to the creation of the mental-hygiene unit and the assignment of a psychiatrist to his staff three years before it was possible to implement this function for psychiatry in official directive.

In view of the tremendous range of the book, however, these critical comments are of minor importance, and it is unqualifiedly recommended as essential reading. It should serve as the basic text in any course on military psychiatry. It deserves the widest possible audience, both military and civilian, both lay and professional.

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DICTATORS AND DISCIPLES. By Gustav Bychowski, M.D. New York: International Universities Press, 1948. 264 p.

When Freud was compelled to flee from Austria, an American editorial carried the caption, *Inmates of Asylum Expel Doctor*. Why people turn to the dictators who suppress mankind's benefactors, is the subject of this able historical and psychoanalytic study. It examines not only the personality pattern to be found in five dictators—Caesar, Cromwell, Robespierre, Hitler, Stalin—but the reasons that incline followers to adopt this kind of father substitute.

Though the author modestly asserts that he confines himself to the psychologic aspects of this problem, he cannot help but see the social and economic ramifications:

> "Blind obedience and submission to a self-appointed authority are made possible only when the people feel weakened in their ego and give up whatever criticism and independence they had developed. Such weakening of the collective ego may occur under the impact of anxiety, fear, and insecurity. Poverty, starvation, fears of imminent danger, are important factors in producing such a condition. Disappointment following a lost war or an exhausting revolution may have the same effect.
>
> "Under such circumstances, the collective ego, harassed by its feeling of helplessness, performs a regression to a more infantile stage and looks anxiously for help, support, and salvation."

In all the chapters, Dr. Bychowski notes how the story of dictatorships usually includes accounts of funeral pyres or other fire celebrations. He observes:

> "From studies of pyromania, we know that setting fire has a definite symbolic and economic meaning. It serves to express both essential drives postulated by psychoanalytic theory. Arson is a discharge of both the erotic and the destructive libido; it is a symbol of both love and hate."

In the dictators themselves—omitting Caesar, about whom the records are scantier—the personality patterns are alike in including such features as these: The home superego imposed continuous and severe repressions on the child. Guilt feelings were many and strong. These words about Cromwell read as if they had been written about Hitler and Stalin: "Another vestige of his childhood experiences was his consuming ambition, the desire for preferment—restrained though it had been by a sense of guilt—his craving for power and domination constituting an additional derivative of sadistic tendencies." Robespierre "developed the sinister habit of noting down the names of people who for one reason or another incurred his censure. These lists of names furnished him with the material for future executions. The lists grew longer as his judgments of people became increasingly caustic and intolerant." Americans will be reminded of the black book kept by Huey Long. About Robespierre:

> "The Incorruptible's belief in himself was so strong, the rationalization of his acts so convincing, that to the very last he considered himself innocent of any crimes.
>
> "His habit of systematically recording the shortcomings and errors of his fellow citizens was a way of justifying in advance the cruelty with which he exterminated his opponents. It also reflected his envy of those who were able to indulge in sensual pleasures."

Psychoanalyzing people who are dead is, of course, an extremely risky business. A practitioner has work enough to do even when he meets the living patient and interviews him for weeks and months. For this reason we must take with caution psychoanalytic judgments not only of dead individuals, but of whole populations. At the same time, this approach to public problems can be of immense help to our world to-day. The horrifying reactions of the collective psyche are of no slight importance to Americans in an age when millions of persons not only rejected democracy, but passionately embraced the chains that promised them bread and security. Hitler, who failed at everything else he tried, achieved a dazzling success—at least for ten years—as a politician. It is still useful for us to ask, Why? He said, "I come to relieve the masses of the burdens of liberty." What is wrong with our home education, our schools, our social and economic institutions, when here also people find liberty too burdensome? Are we fooling ourselves when we call ourselves a country of mature persons? If Dr. Bychowski's chapters disturb us at all, they will do us good.

HENRY NEUMANN.

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THE DRIVING FORCES OF HUMAN NATURE. By Thomas Verner Moore, M.D. New York: Grune and Stratton, 1948. 461 p.

The author of this book states that it is an attempt at a synthesis of various currents in modern psychological thought. It was philosophy that first attempted to study and to interpret the phenomena of mental life. Then came the development of experimental psychology, when men tried to obtain further facts by the experimental procedure and a new insight into the nature of mental life. Then came psychiatry, with its practical problem of understanding human mental life in order to treat the disorders of the mind. The author has endeavored to integrate these three trends in the development of modern psychology.

This book is an amplification of his earlier work, *Dynamic Psychology,* and is divided into the following sections: *Historical Introduction to Psychology; Consciousness and the Unconscious; Human Emotional Life; The Psychopathology of Emotional Life; The Driving Forces of Human Nature and Their Adjustment; The Will and Voluntary Action;* and *The Problems of Volitional Adjustment.*

Part I is divided into chapters on the conception of psychology and the foci of development in American psychology. This latter chapter discusses in interesting fashion the important contributions of William James, Edward Boring, George Ladd, Granville Hall, Edward

Titchener, Monsignor Edward Pace, and the works of other prominent figures in the history of American psychology.

Throughout the book the attitudes of the Catholic Church are clearly stated and represent an important contribution to the integration of Catholicism with modern psychiatric thinking. Such matters as the philosophy of will are discussed with this in mind.

There are many equations and charts which do not add materially to the text. There are comparatively few references to the more recent schools of psychiatry. Psychoanalytic theories and contributions are only briefly mentioned. The psychology of the emotions is presented with a considerable amount of material on physiological research and references to the theories of St. Thomas, James, and Watson. References are also made to the earlier works of Arnold Gesell.

There are separate chapters on the gastrointestinal neuroses and the cardiac neuroses. Moore shows that the demands of life may cause cardiac disturbances not only in patients with organic disease, but also in persons whose hearts are frankly normal, without any structural defects.

The book is well illustrated with case studies and with interview material which describes quite well the author's technique of psychotherapy. There is, however, a notable lack of material on the basic mental mechanisms. In the discussion of treatment, the author states, "One should find out the motivation which lies at the bottom of the condition and then attempt to find, for the patient, some more satisfactory solution, and, if possible, create a desire to get well. He speaks of the suggestive means of prophylaxis, and the channels of compensation and sublimation.

In the chapter on the "Parataxes of Defense," the author states that "whenever it is possible for us to avoid or escape an unpleasant situation, we experience a strong tendency to do so. Whether the difficulty be little or great, there is a natural tendency to avoid it. In some, this tendency may be obscured by ideals of conduct, but from birth it exists in all and no one entirely overcomes it. The difficulty may come to us from within—from painful memories or unpleasant considerations." These defense reactions are forgetting, the transfer of blame, negativism, incapacities in both children and adults, and the parataxes of special disablement.

The author endeavors to point out the difference between compensators and sublimators in his discussion of sublimation. Some people never sublimate and cannot be persuaded to seek a form of activity that does not contribute to their own self-aggrandizement.

In the chapter, *Adjustment in the Home and in the Family of Nations*, the home is described as a social unit. As such, it must have

a center of authority. The center of authority is the father; he may be likened to the abbot of a monastery and the mother to a brother cellarer. The home, like the monastery, is a school of the service of God.

The author is particularly well qualified to relate psychiatry to Catholicism because of his training and background as a monk of the Order of St. Benedict and as a practicing clinical psychiatrist. With such a religious and scholarly background, he was able to make a valuable contribution in the field of psychiatry as related to religion.

LEO MALETZ.

Lynn, Massachusetts.

MEDICAL HYPNOSIS. By Lewis R. Wolberg, M.D. New York: Grune and Stratton, 1948. 442 p.

These two volumes on medical hypnosis come from the pen of a man who is to-day one of the most active workers in the application of hypnosis to psychotherapy. They follow by three years the publication of his *Hypnoanalysis.*

The first volume discusses the history and technique of hypnosis and then the applications of hypnotherapy. These latter are discussed under the headings of syndromes, ranging from conversion hysteria to psychosis. The second volume discusses the use of hypnosis under the headings of various kinds of psychotherapy—the major divisions being symptom removal, psychobiologic therapy, and psychoanalytic therapy. There are also included verbatim interviews illustrating these various uses of hypnosis. The author's own division of the two volumes is into "principles" and "practice," but this is not adhered to.

Though there is much to be said for the usefulness of some sections of these two volumes, the total effect is disappointing. It is difficult to discern the author's main purpose in writing them. Though they are entitled *medical hypnosis,* they actually seem an attempt to present the author's views on psychodynamics and psychotherapy. It is certainly true that a discussion of hypnosis in psychotherapy will necessarily include much material on psychodynamics and psychotherapy. Especially is this true in a work which maintains that hypnosis can be intelligently used in psychotherapy only as an adjunct to a psychotherapeutic program the goals of which are determined by the usual indications for choice of psychotherapeutic technique. There is no such thing as "hypnotherapy." There is rather the use of hypnosis as an auxiliary technique in various kinds of psychotherapy. But in these volumes hypnosis often seems to be the excuse for launching into general discussions of psychodynamics, psychotherapy, and even general psychiatry. Apart from

the irritating effect this has on the reader who has been led to expect a work more specifically oriented toward hypnosis, the points specially relevant to hypnosis are in danger of being buried.

Even the major thesis stated above—that there is no such thing as a specific hypnotherapy—is in danger of being obscured by the discussion of hypnosis under the categories of syndromes. This difficulty arises from the more basic issue of whether psychotherapy is to be profitably discussed under the heading of various syndromes, as if there were a specific psychotherapy for each. It seems to the reviewer that a modern discussion of psychotherapy should be organized around such foci as defense mechanisms and ego-adaptation techniques with illustrations by reference to various syndromes in the course of the discussion, rather than the reverse, as is done in these volumes.

The author's second attempt to solve this problem—that of organizing the discussion around types of psychotherapy—seems to me a better approach, but it suffers from an arbitrary, pseudo-exact division of psychotherapies. Under psychobiologic therapy, for example, there are separate discussions of hypnosis in guidance, reassurance, persuasion, desensitization, reëducation, and reconditioning. Modern discussions of psychotherapy are organizing such concepts along quite different lines—such as transference, insight, and "corrective emotional experience."

In this connection it is also to be noted that the author broadens the use of the term "psychoanalysis." It is true that in the literature the term "hypnoanalysis" has come to mean a combination of hypnosis with techniques of psychological analysis which may be superficial or deep. But here the author discusses, under "hypnosis in psychoanalytic therapy," such procedures as "hypnoanalytic desensitization" and reëducation through psychoanalytic insight. His category, "hypnoanalysis with analysis of the transference," is the only one that should be classed as "hypnosis in psychoanalytic therapy." This part of the discussion is the one that does the least justice to the problems involved.

Another difficulty in discerning the author's main purpose is that while, on the whole, the volumes read like a textbook for the presentation of secure and accepted knowledge, the discussions of hypnosis sometimes branch off into problems in the forefront of hypnotic research, which are not accorded the status of unsolved questions, but rather are discussed as if the answers were well established. Though the discussions are often interesting, they seem to the reviewer to convey an erroneous impression of the state of knowledge in the field. Examples of such problems are the changes in ego and superego functioning in hypnosis, the nature of hypnotic dreams,

and the manifold problems of "transference" in hypnosis, both theoretical and in the technique of therapy.

The mode of organization and the author's style make the volumes unduly repetitious and wordy.

Despite all these adverse comments, it is nevertheless true that much is to be said in favor of the book. Techniques of hypnotic induction—despite the fact that their theory is incompletely dealt with—are given in verbatim detail. It is good to find verbatim case data—although the analysis of the material is quite sketchy. The hypothesis of changing motivations in the hypnotic subject—presented in the chapter on the nature of hypnosis—is an interesting one. A consistent attempt—probably the most thoroughgoing attempt in the literature of hypnotherapy—is made to understand the hypnotic relationship in terms of the total setting of the interpersonal relationship between hypnotist and subject.

MERTON M. GILL.

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AN OUTLINE OF PSYCHOANALYSIS. By Sigmund Freud. Translated by James Strachey. New York: W. W. Norton and Company, 1949. 127 p.

This book presents a series of papers that Freud began writing in London in July, 1938, shortly after his rescue by British and French friends from the Nazis who had held him hostage in Vienna. At the time, he was eighty-two years old and the observations, now published in book form, appeared simultaneously in 1940 in the *International Zeitschrift für Psychoanalyse* and *Imago* and then in translation in the *International Journal of Psychoanalysis*. They may be regarded as an effort to epitomize his work of a lifetime. Despite his age, Freud had lost nothing of his mastery of style, which in earlier years won for him the Goethe prize. His writing is clear, pungent, and free-flowing. The translation from the German, by James Strachey, who contributes a brief preface, reads easily, but the translator has achieved this without sacrificing accuracy or distorting the feeling of the original text.

In no sense can this little book be regarded as a basic outline of psychoanalysis for the uninitiated who would like to become acquainted with Freud's psychological system—called psychoanalysis—or the philosophical attitude he developed from it. However, for those who have become familiar with Freud's thinking, it offers the final thoughts of the master's mind for reëxamination and reflection.

The book, all in all approximately only 75 ordinary pages, has been divided into three parts entitled, respectively, *The Mind and Its Workings*, in which Freud recapitulates his theory of psychoanalysis;

The Practical Task, which deals with the technique of psychoanalysis; and, finally, *The Theoretical Yield,* which in a sense is Freud's own criticism and evaluation of his theories. These three parts are in turn divided into brief chapters, some of which, such as the *Technique of Psychoanalysis,* should be readily comprehensible to the intelligent lay reader; but several other chapters are so condensed that they must be read, reread, and pondered even by experienced students of psychoanalysis.

Freud's position in this work toward some current controversial issues in psychoanalysis may be briefly noted. For instance, in discussing the categories of the mind that he defined about twenty-five years ago (the superego, the ego, and the id), Freud continues to speak of them as well-circumscribed areas rather than as being fluid and continuously subject to change. He reaffirms the destructive (death) instinct—whose "final aim is to reduce living things to an inorganic state"—a concept of energy disposal that many analysts have found it difficult to accept. He also implies that self-destructiveness "may do the individual to death" when the libido has become fixated in some disadvantageous way (p. 22), which opens the way for speculation as to the origin of neoplastic illnesses. He locates conscious processes on the periphery of the ego (p. 41) and brings the dream work that he investigated long before he developed the categories of the mind into relationship with them (p. 52) for the first time to this reviewer's knowledge. These are only a few of the great number of problems chosen from the earlier portion of the book that arouse the interest of the close students of psychoanalysis.

It is doubtful whether so complex a subject as psychoanalysis can be covered in any outline, and the intelligent person, physician or layman, who wishes to understand the concepts and goals of psychoanalysis must resort to other books that present its essential operation.

C. P. Oberndorf.

New York City.

How Psychiatry Helps. By Phillip Polatin, M.D. and Ellen C. Philtine. New York: Harper and Brothers, 1949. 242 p.

The recent emphasis on psychiatry in the press, the movies, and the radio has tended to stimulate public interest and curiosity in psychological subjects. Unfortunately, much of the written material available to the public is produced by enthusiastic, but misinformed lay persons who have neither the background nor the experience to promulgate ideas on psychiatry for public consumption. What has been required for some years has been a simple, though comprehensive, book written by a psychiatric authority who understands how to communicate ideas on so complex a topic as psychiatry in terms under-

standable to the average person. The present work, *How Psychiatry Helps,* appears to fulfill this need.

The opening chapter of the book contains a brief description in non-technical language of the most common neurotic and psychotic syndromes, mental deficiency, alcoholism, and drug addiction. Definitions and delineation of the functions of psychiatrist, neurologist, psychoanalyst, psychologist, and case-worker are given. The second chapter presents an excellent account of the process of psychoanalysis and strives to clarify the difference between psychoanalysis and other forms of psychotherapy.

The remaining chapters contain, in the opinion of the reviewer, the best descriptions yet available in the popular literature of the uses and limitations of the various forms of psychiatric treatment, including direct-interview psychotherapy, distributive analysis, hypnosis, occupational therapy, group therapy, child therapy, shock therapy, psycho-surgery, narcosynthesis, and drug treatments. There are also chapters on psychosomatic medicine; on the treatment of alcoholism, drug addiction, epilepsy, and general paresis; and on preventive psychiatry, with a succinct, well-conceived "Bill of Rights" for children. There is, finally, an appendix which outlines the psychiatric facilities available in the various states, and lists sources of information regarding available facilities.

This work is highly recommended as orientation material for (1) students in psychiatry, psychology, and case-work; (2) professionals—physicians, public-health officers, lawyers, court authorities, social workers, nurses, and teachers—who come into contact with emotionally ill people; and (3) lay persons who seek information or clarification on the general subject of psychiatric treatment.

LEWIS R. WOLBERG.

New York City.

WHICH WAY OUT? By C. P. Oberndorf, M.D. New York: International Universities Press, 1948. 236 p.

The literary ability of Dr. Oberndorf is widely recognized; this time he has demonstrated it in a new way. This little book contains eleven short stories, "based on the experience of a psychiatrist," to quote the subtitle of the book.

The scenes are laid in hospital and in the community, and the stories deal in an entertaining and readily comprehensible way with some of the problems of life with which the psychiatrist deals—hysterical paralysis, the Œdipus situation, suicide, frustrations of various sorts.

An extended introduction by the author makes some sound general comments on the tales and on the problems of mental disorder and

its prevention. The book is intended primarily for the lay reader, and will be read with profit and enjoyment by all who are interested in the wellsprings of human conduct.

WINFRED OVERHOLSER.

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FUNDAMENTALS OF PSYCHOANALYSIS. By Franz Alexander, M.D. New York: W. W. Norton and Company, 1948. 312 p.

In this book Franz Alexander has written a concise, fluent exposition of psychoanalysis in a form that can be understood by the average student of psychology, medicine, or the social sciences. This volume was a development from the author's earlier book, *The Medical Value of Psychoanalysis*. In his preface, he indicates that he will touch on the present stage of evolution of psychoanalysis and analytic thinking, instead of beginning with the early experiments of Freud, as is often done in writing about this subject for others than psychiatrists. This point of departure gives a slightly different tone to the volume—a flavor that makes it more readable and less pedantic than other texts in this field. Both under the section on basic principles of psychodynamics and in the section on therapy, recent improvements, such as the developments of the Chicago analytic school and others, are enumerated and fitted into the total analytic structure.

An outstanding aspect of Alexander's book is the feeling of fluency one gets, and the absence of intricate metapsychological disquisitions. The book is lucidly and directly written. Nor does it spare statements indicating doubt as to our present competence to understand certain complex psychological phenomena.

An interesting development is the author's extension of the principle of homeostasis (Cannon) which was apparently worked out also by Fechner under the term "principle of stability."

The principle of stability and the principles of inertia explain, first, how the ego defends itself against unconscious drives socially destructive to the personality, and second, how these elements become converted into symptoms—*i.e.*, become automatic—under the influence of the economy principle. Thus Alexander utilizes an explanation of ego function based on movements of psychic energy within the personality as the latter meets social opportunities and frustrations. This leads to a discussion of vector analysis of the life process. Such a consideration relates to the way in which psychic energy is utilized by the ego in self-preservative behavior, the remainder, "not needed to maintain life in equilibrium" (p. 44), spilling over as surplus energy into sexual activity.

The volume is conveniently divided into sections on basic principles, functions of the ego and its failures, the psychology of dreaming, the

psychopathology of clinical conditions, and finally a discussion of psychoanalytic therapy. The volume is an excellent example of intelligent presentation of analysis. A perennial obsessive doubt arises in the mind of the analyst whether any person who is not trained or immersed in analytic contacts with patients, can by reading perceive all the movements of the psychic forces. Nevertheless, this doubt should not interfere with an appreciation by the reader of what happens in the minds of the analyst and the patient.

The book is highly recommended to all who have a theoretical and a practical interest in psychotherapy.

WALTER BROMBERG.

Reno, Nevada.

BULWARKS AGAINST CRIME. Edited by Marjorie Bell. New York: National Probation and Parole Association, 1949. 359 p.

For a number of years, the annual publications of the National Probation and Parole Association have been a most valuable source of information regarding the various phases of correctional work. The 1948 Yearbook entitled, *Bulwarks against Crime*, contains twenty-four papers given at the annual conference of the association in Atlantic City in April, 1948, and some other conferences.

Walter C. Reckless, professor of sociology at Ohio State University, discusses "Significant Trends in the Treatment of Crime and Delinquency." He particularly deals with new approaches to the treatment of juveniles and adults in correctional institutions and mentions among others the rôle that group therapy is beginning to play within these settings. Concerning probation and parole work, he stresses that case-work in an authoritarian frame of reference is to-day an accepted policy and can be a definite asset. As he states, "the crux of the matter hinges on the adequate interpretation given the probationer or parolee as he is received for supervision and planning."

Edwin J. Lukas, Executive Director, Society for the Prevention of Crime, New York City, deals with "Peno-correctional Philosophy in Retrospect." He traces the development of the Auburn system of penal treatment and sketches the one-hundred-and-twenty-five-year-old history of institutions for delinquent children. He closes with a brief appraisal of the idea of the Youth Correction Authority plan, as promoted by the American Law Institute, and calls it "the brightest development on the horizon of peno-correctional philosophy."

Dr. Ralph S. Banay, Director of Research on Social Deviations, at Columbia University, New York, uses two case records of young girls in his paper on "Crime and Aftermath." His thesis is that "we need, above all, understanding of defective and distorted personalities," whom he calls "unhappy people."

Another article in the first section of this book dealing with "Current Approaches To Crime Treatment," was contributed by Leon T. Stern, Secretary of the Pennsylvania Committee on Penal Affairs. His paper, *Popular or Scientific Evaluation of Probation and Parole?* is based upon a study of 14,000 records of prisoners in the Eastern State Penitentiary and the Philadelphia County Prison, from the point of view of parole success. In this connection, Mr. Stern also evaluates the modern attempts at prediction of the success of probation and parole.

George H. Dession, professor of law at Yale University, discusses "Law and Social Control," and emphasizes that "law and criminology have come to speak of social protection rather than in the older symbols of vengeance, retribution, and expiation."

The second group of articles deals with "Special Child and Family Services." Katharine F. Lenroot, Chief of the U. S. Children's Bureau, contributes a detailed paper on "The Government and Child Welfare," in which she describes the beginnings of the juvenile-court movement and the formulation of standards for a model juvenile-court act, the early beginnings of mothers-assistance laws, the visiting-teacher movement, the several White House Conferences on Children, and the provisions of the Social Security Act of 1935 and its more recent amendments.

Social services in a divorce court are described by William L. Fiedler, Supervisor of the Family Service Division of the Cincinnati Juvenile and Domestic Relations Court. The courts in Ohio have for a long time been known for their comprehensive jurisdiction in family matters, including divorce; the social services in such a court, therefore, must necessarily include plans for the support and custody of children in cases of divorce.

Similarly, William J. Harper, Director of Probation, Westchester County, New York, describes social services in family problems from the point of view of the court. He stresses the close coöperation between the children's court and the police, the district attorney, and the Society for the Prevention of Cruelty to Children.

The third group of articles deals with "The Group In Camp and Training School." S. R. Slavson, Director of Group Therapy, Jewish Board of Guardians, New York, contributes a paper on "Milieu and Group Therapy for Delinquents." This paper is partly based on experience in the Hawthorne-Cedar Knolls School of the Jewish Board of Guardians. He emphasizes, *inter alia*, that "members of therapy groups in an institution display a remarkable unanimity in their common hostility toward the school, the staff, and especially the director." The writer feels that this initial resistance can be overcome by the therapist by convincing the group members of his interest

in them. He considers group psychotherapy as most beneficial in institutions for adolescents.

Other articles in this section include *The Value of Group Living in Institution Treatment,* by Kenneth I. Wollan, Director, Connecticut Junior Republic, Litchfield, Connecticut; *The Place of the Training School,* by Harry W. Lindeman, Judge, Essex County Juvenile and Domestic Relations Court, Newark, New Jersey; *The Institution Looks Ahead,* by Carroll R. Minor, Superintendent, Beaumont Industrial School, Beaumont, Virginia; and *The Natural Bridge Camp,* by H. G. Moeller, Supervisor, Juvenile Section, Bureau of Prisons, U. S. Department of Justice, Washington, D. C. This latter description of a forestry camp for delinquent boys who are federal offenders is of particular value, since it points up the great possibilities that such camps can have in a modern correctional program. In several states, notably California, considerable use has been made of this kind of treatment facility.

The section, *Guiding The Adult Offender,* consists of three articles: *Interviewing—A Two Way Process,* by G. I. Giardini, Superintendent of Parole Supervision, Pennsylvania Board of Parole, which discusses interviewing for factual material, as well as interviewing in the counseling and treatment process. It also describes modern methods of in-service training in interviewing, with the use of the electronic recording device.

Evelyn C. Hyman, Case Supervisor, Protective Service for Girls, Department of Public Welfare, Baltimore, Maryland, discusses the case-work approach in handling promiscuous girls, in her paper entitled, *Holding the Promiscuous Girl Accountable for Her Own Behavior.* It includes a detailed interview with such a girl in a police lock-up.

Supervising the Adult Parolee is presented by F. Murray Benson, Director and Chairman of the Maryland State Board of Parole and Probation. Legal-aid services are discussed by Martin V. Callagy, Attorney-in-Chief, Legal Aid Society, New York City, and Arthur E. Schoepfer, Executive Director, Standing Committee on Legal Aid Work, American Bar Association, Boston.

Preventive aspects of the subject are high-lighted from various levels. Douglas H. MacNeil, of the Department of Institutions and Agencies, New Jersey, in his paper, *Two and One-half Years of State-Local Collaboration in Delinquency Prevention,* describes the New Jersey program of sponsoring municipal youth-guidance councils and the state-wide services rendered to local juvenile courts, schools, and recreational agencies, by the Division of Community Services for Delinquency Prevention, of the Department of Institutions and Agencies. Special reference is made to the work of the child-study

center at Allaire in the psychiatric study and treatment of emotionally disturbed children.

J. Francis Finnegan, Executive Director of the Crime Prevention Association of Philadelphia, speaking on "The Philadelphia Conference On the Prevention and Control of Juvenile Delinquency," describes how the impetus of the National Conference on Prevention and Control of Juvenile Delinquency, held in Washington in November, 1946, has been translated into local fact-finding and social action.

Sampson G. Smith, Somerset County Superintendent of Schools, Somerville, New Jersey, in his paper, *The Schools and Delinquency,* calls for a close coöperation of schools and social agencies.

John M. Zuck, probation officer of the County of Los Angeles, California, describes in detail the very comprehensive and extensive program of crime prevention in his community. His paper, *The Probation Officer Participates in Delinquency Prevention,* stresses the importance of local community councils in such a program. He also mentions a special program of assigning a probation officer to a neighborhood of high delinquency rates for group work, without specific responsibility for individual cases. As he describes it, the probation officer's job is "to promote group activity and group planning while inviting the confidence of the individual members of the group and gaining an acceptance which would pave the way for constructive attitudes toward the adult community." So far, 17 deputy probation officers have been assigned to this kind of work.

The international aspect of the conference in Atlantic City, which was held as part of the International Conference of Social Work, is stressed by two papers. Wanda Grabinska, former Judge of the Juvenile Court, Warsaw, Poland, speaks on "Backgrounds of Delinquency in War-torn Countries," basing her description on experiences in her native Poland and in Great Britain, where she spent part of the war period. She also includes in her study the children in displaced persons camps.

Dr. Thorsten Sellin, Professor of Sociology, University of Pennsylvania, analyzes "Probation and Parole of Adult Offenders in Sweden." Regarding pre-sentence investigation, Dr. Sellin mentions a new law which makes it obligatory to have such investigations made whenever the defendant is under twenty-one years of age at the time of arrest. He also describes an entirely novel feature—obligatory parole; this means that a prisoner who has not applied for and been granted parole earlier, must be paroled when he has served five-sixths of his term.

As usual, a legal digest, prepared by Sol Rubin, of the staff of the National Probation and Parole Association, is added, enumerating

legislation and court decisions that affect juvenile courts, probation, and parole, during 1948, in the various states of the Union.

In the final chapter, the work of the National Probation and Parole Association is described in detail. A most welcome step was taken in combining the activities of the National Probation Association with those of the American Parole Association. The National Probation Association is now called "The National Probation and Parole Association" and devotes itself with vigor and strength to the promotion of modern principles and practices in both fields of correctional work, probation and parole, which, in spite of legal differences, have so much in common in their social, psychological, and administrative implications.

JOHN OTTO REINEMANN.

Municipal Court of Philadelphia.

JUVENILE DELINQUENCY. By Paul W. Tappan. New York: McGraw-Hill Book Company, 1949. 602 p.

Professor Tappan's scholarly and broad treatment of his subject is a welcome addition to current literature. Structurally, his book has four major divisions: Part I, *The Nature and Extent of Delinquency;* Part II, *Causation;* Part III, *The Delinquent in Court;* Part IV, *Treatment.* His material is well organized and comprehensive to an unusual degree, and his presentation reflects a monumental labor of research and synthesis. The bibliography should be of great value to students and practitioners alike.

While Dr. Tappan's approach is essentially legal and sociological, he emphasizes case-work philosophy and principles, but unfortunately tends to commingle these with administrative processes. A pervasive theme meriting comment is his insistence that social study should not precede an adjudication of delinquency. Fear is expressed that this would be a violation of constitutional rights. He overlooks the fact that most children who are brought into court have already acknowledged their misbehavior, and the individual study represents timely help, not a threat, not a punishment.

In advanced courts, especially those that utilize the referee system, there is ample safeguarding of constitutional rights with case-study beginning at intake in skillfully conducted informal hearings. An essential feature is a determination that the misconduct complained of has occurred. There follows a continuity of service with the application of modern mental-hygiene concepts for the benefit of often confused, bewildered children and their parents. This practice represents remarkable progress, little publicized, but worthy of emulation.

The author's objection suggests a misunderstanding of the nature

and efficacy of generic case-work. Those who work directly with children know that their misconduct is a danger signal pointing to something awry in the child himself, his family, school, or neighborhood. Usually, the sooner skilled help is available, the more favorable are the results.

An important way in which a standard children's court differs markedly from most criminal courts is that individual study and treatment are made available prior to rather than only after a final adjudication. A return to the practice customary in adult courts would be a serious regression.

Professor Tappan recognizes that probation departments have major treatment functions and is aware of the many difficulties with which probation personnel are confronted. He draws attention to the fallacy of expecting other than superficial service when case loads are excessive and to the frustrations attendant upon diffusion of energies. A plea is made for quality of performance which is as dependent upon sound leadership as upon competent personnel.

It is apparent to many social workers that all case-work should be family-oriented, whatever the agency setting may be. Hence, it would be inadvisable to follow Dr. Tappan's recommendation that where family service is needed, a transfer should be made to a private agency. Experience shows that in many cases, after these transfers have been made, the agencies then request the court to resume its service to the children and adults concerned. Such re-reference of cases is based upon an awareness of the court's powers to implement treatment services through the exercise of judicial functions. Coöperative effort between private agencies and the children's court does not necessitate or validate a shifting of responsibility from the court to those agencies.

To contend that family case-work should be left to private groups is reminiscent of the older controversy between public and private agencies in the realm of relief-giving. In the 1930's, with the rapid growth of relief organizations, some social workers advocated a split of function, with public bodies administering relief and private agencies rendering the accompanying services. The conflict has been resolved with increasing understanding that the giving of relief is basically a case-work function and that certain treatment services supplementary to it should be rendered by the same agency.

To transplant this conflict into the area of children's courts would be regrettable. Their judges should be encouraged to improve the caliber of their staffs, not by an artificial division of function, but by an acceptance of their rôle as family-service units.

HARRIET L. GOLDBERG.

Domestic Relations Court, Toledo, Ohio.

ALCOHOL AND HUMAN AFFAIRS. By Willard B. Spalding and John R. Montague, M.D. Yonkers-on-Hudson, New York: World Book Company, 1949. 248 p.

This is a small book written primarily for students. The authors state that its aim is to present factual information drawn from numerous reliable sources. It has chapters dealing with the manufacture of alcohol, the size of the alcohol industry, the effects of alcohol on the body, the effects on society, the control of drinking by law, the attitude of religious bodies toward the use of alcohol, methods for helping alcoholics, and the attitude that should be taken by an individual toward the problem of alcohol. In the appendix the use of tobacco and narcotics and other drugs is discussed.

The authors state the characteristic interests in and attitudes toward the liquor problem in these words: "Some use alcohol and approve of it. Others manufacture and sell alcohol; they may or may not use it themselves. Still others disapprove of the making and use of liquor. A few cannot stop themselves from excessive and dangerous drinking." These attitudes are discussed at length in one of the chapters. It is interesting to note that the "*few who cannot stop themselves from excessive and dangerous drinking*" numbered 1,500,000 alcoholic addicts, of which 750,000 were chronic alcoholics, in the United States in 1945, according to estimates quoted by the authors on page 97. The estimates were made by E. M. Jellinek.

The authors apparently believe that the estimates give a reliable picture of conditions. They fail to point out, however, that no enumeration of drinkers of any class is made by government authorities. Such enumeration would be practically impossible. Record, of course, is made of the persons arrested for drunken driving and for disorderly conduct due to drunkenness, and of alcoholic patients who enter institutions. The numbers are large instead of small, and Dr. Jellinek's figures may be approximately correct.

The authors give more definite figures concerning the quantity of alcoholic beverages sold in the United States for the years 1934, 1940, 1946, and 1947. The figures are taken from different sources, but presumably are fairly accurate. The increase in total consumption of alcoholic beverages was from 1.3 billion gallons in 1934 to over 3 billion gallons in 1947. Figures for consumer expenditures for alcoholic beverages for the same years are also given. The increase shown here is from 2 billion dollars in 1934 to 9.6 billion dollars in 1947. The source of the figures is the U. S. Department of Commerce.

Other figures given by the authors relate to the grain and fruits used in beverage alcohol in 1946. As would be expected, the figures are enormous. Other useful figures cited by the authors give a classi-

fication of wholesale and retail liquor dealers for 1947. The total shown is 469,183. Still other figures relate to the advertising bill of liquor manufacturers, the taxes paid by the liquor traffic, the arrests chargeable to the use of liquor, and the annual crime bill chargeable to liquor. The authors estimate the last item to be $2,400,000,000.

A useful chapter deals with the efforts made to control the liquor traffic. None of the methods described seems to be highly effective.

The authors give wholesome advice to students relative to the use of liquor and present ways and means of helping people who drink too much.

The book as a whole is to be commended for its unbiased presentation of data. The information given may not be entirely acceptable to statisticians, but it serves its purpose in showing the enormous waste of money and life caused by the liquor traffic. The thoughtful reader can draw but one conclusion—that something effective should be done about the matter.

HORATIO M. POLLOCK.

Middleburgh, New York.

THERAPEUTIC SOCIAL CLUBS. Edited by Joshua Bierer, M.D. London: H. K. Lewis and Company, 1948. 73 p.

This is the first comprehensive publication about a movement that Dr. Bierer started nearly ten years ago. Since 1940, he and his collaborators have published a number of articles in England promoting the idea of "social psychiatry" as an active link between mental hygiene in general and group therapy. This movement is based on the concept of Adlerian psychology which has—in America to a greater extent than in Europe—taken a back seat during the last fifteen years while other psychoanalytic schools moved forcefully into the foreground of public and professional attention.

Dr. E. B. Strauss, in his introduction to the booklet, emphasizes the paradoxical situation created by the fact that Alfred Adler decided to call his school of thinking "Individual Psychology," while actually "the core of his teaching deals with man as a social animal rather than as a creature with an individual destiny." "Perhaps this misnomer is one of the reasons why Adlerian psychotherapy has been somewhat eclipsed as a coherent system."

The Institute of Social Psychiatry in London, of which Dr. Bierer is the founder and medical director, is the center for the therapeutic social clubs. It is doing "systematic research in the causation, the diagnosis and treatment of nervous and mental illnesses with special emphasis laid on its social side." Besides its research program, the institute will train "social therapists" and students in social psychiatry. It is farther interested in the establishment of "centers of

readaptation to normal life, rehabilitation and occupational centers, day hospitals, therapeutic social clubs, and other self-governed associations of patients."

This is a highly interesting and stimulating program, of great importance for the promotion of mental hygiene. The collected papers in the booklet give us a survey of the basic principles of "social-club therapy" (Dr. J. Bierer and Dr. Paul Senft); of the organization of clubs for inpatients and for outpatients, for the chronically ill, and for more acute cases of emotional disturbance (Dr. Donald Blair, Miss Kathleen Thompson, Dr. M. B. Brody, Dr. Karl Aron, Dr. E. D. Taylor, and others); and of the different therapeutic techniques used (art circles, and so on). Finally, a number of short reports about the functions of social clubs and rehabilitation centers in England and Scotland and a timely warning—*The Dangers of Social Club Therapy*, by Peter Scott— are included.

The reader is impressed by the enthusiasm and the understanding of the social problems of the mentally ill patient, an understanding that is shared equally by all the contributors. It is, on the other hand, unavoidable that the different authors should approach the problems of group mental health in different ways. From the point of view of group psychotherapy, no clear decision is made whether a therapeutic effect is to be achieved by analytic or by repressive techniques. Self-government and the stimulation of spontaneity in the patient group are emphasized, but reality factors seem to intervene rather often. One has occasionally the impression that little tricks and intricate and subtle methods are used in order to take some rights away from the patient clubs through the back door which in the beginning had been introduced with great emphasis. The maintenance of "discipline"—or, rather, of a cohesive spirit in a group of mentally ill persons—is indeed a serious problem in any group-therapeutic approach.

The careful selection of patients, as well as limitation of the size of the group (eight patients as a maximum), seems at the present moment the best safeguard for therapeutic effects. Both these safeguards are difficult to apply in the setting described in this booklet.

While deeper therapeutic effects on seriously ill patients seem, therefore, greatly limited (the danger of undue pressure exerted on the weak patient ego by the group impact is duly emphasized) and while the claim for a "specific treatment against asociability" appears premature, the value of the clubs as "complementary treatment" and as a method for the promotion of mental hygiene among convalescents, relatives of patients, hospital staffs, and the general public can be hardly overemphasized.

It is the conviction that no patient is too sick to have some ability left for social relations, and the honest and earnest effort to use

these remnants of social ability for the rehabilitation of the personality and for the reintegration of the individual into the group, that make this short treatise an important and valid contribution to the mental hygiene of the emotionally disturbed patient and, for that matter, a contribution to the mental hygiene of the group as the representative of the community.

WILFRED C. HULSE.

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Long Island College of Medicine.

HOW TO THINK ABOUT OURSELVES. By Bonaro Overstreet. New York: Harper and Brothers, 1948. 205 p.

This is a very fine book on the healthy personality-at-work in every sphere of daily living. Several of my young student friends found it so attractive in form and content that I finally had to keep my copy out of sight, to have it when I wanted it myself. Its style is refreshingly clear, with simple examples drawn from everyday living that make its meanings directly applicable to the reader's own circumstances. The very chapter headings are inviting—for example, *The Self Meets a Changing World, Heir to a Tradition, The Creative Self, The Self that Love Makes, Of Error and Self-Deception, Building a Personal Philosophy.*

Part I, *The Framework of Experience,* is a crystallization of most of the great basic tenets of modern culture. In these first seventy pages the author has set in clear perspective critical questions with regard to an adequate philosophy of life, a practical psychology for sensitive and full living. She demonstrates that "each of us is both the product and the maker of a culture," and that perhaps our greatest need is for "unlimited possibility vision . . . . too many of us are blind to the clean, strong possibilities of our culture because we do not dislike the tawdriness by which they are concealed."

In these early chapters, Mrs. Overstreet has accurately diagnosed "our major weaknesses as makers of a new culture that will fitly meet the new demands of a new age." But, like a wise physician, she also has abounding faith that we "stand a chance of responding to new problems with less conclusive futility . . . . that we can develop a keen enough possibility vision to see what must be done and can be done"—and to do it.

Part II, *Linkages with Life,* discusses how to think about ourselves at work, as persons among people, as loving and beloved individuals. With clear insight into our need for happy self-fulfillment, the author redefines work in the sound sense of its great values in companionships and creation. She indulges in no ethereal nonesense either

about mankind in general or about particular individuals, but neither is she afraid to speak out definitely for man's chief duty—to aid by every action the building of a better world through and for genuine love of God and neighbor.

One of her remarks comes to mind now: "What has terribly come to pass is that the pattern of *each-for-himself* has become the dominant pattern of our world. The pattern of *each-for-all*, though we still pay it lip service, has been relegated to secondary place . . . . to serve as a kind of mild palliative when competition has gone too destructively far. . . . In relation to his fellow men modern man is trying to live out a contradiction. . . . Man *is* a social animal. . . . But it takes a lifetime to build habits and outlooks to fit that meaning."

Surely here is a large dose of the common sense that we as physicians, psychologists, social workers, teachers, parents need.

Chapter XII, entitled *The Self that Love Makes*, brings the reader face to face with such important questions as "How capable are we of making other people feel so emotionally secure that they can hazard the experience of outreach rather than of withdrawal from life?" and, "Do we enjoy equality relationships as much or more than those of either submission or domination?"

The final chapters, under Part III, *Peculiarly Human*, reveal the author's intimate and accurate knowledge of human personality in the framework of the human nervous system. She ably details the art of "the primary act of philosophy . . . . that of fitting the self into the human race . . . . fitting the known into the larger unknown."

How to Think About Ourselves is a book that will be of value to scientist and layman alike, because it will enable both to think far more clearly and wisely about themselves.

JOHN CRAWFORD.

Wagner College, Staten Island, New York.

PASTORAL COUNSELING. By Seward Hiltner. Nashville, Tennessee: Abingdon-Cokesbury Press, 1949. 291 p.

For some years the literature of pastoral care—the minister's work with individuals—has been growing steadily. We have drawn heavily upon psychiatry, and many psychiatrists, while being careful not to mention the work of the clergymen, have not hesitated to admit privately that their books have sold far better to ministers than to non-psychiatric physicians.

And now Seward Hiltner, a minister, writes a book for ministers that should challenge the attention of psychiatrists and mental hygienists. The author of *Pastoral Counseling* has served for ten years as Director of the Department of Religion and Health (now called the

Department of Pastoral Services) of the Federal Council of Churches. In this capacity he has moved freely across the major professions whose work is *helping people.* He is probably more familiar than any writer in America with the ideologies and literature of the combined fields of psychiatry, psychology, social work, and pastoral care. There are major gaps between these points of view, as there are between the humanitarian professions. Hiltner's book makes a significant contribution toward bridging these gaps. This contribution lies rather in the arrangement of the material than in any particularly original description of the task of pastoral counseling.

The material is presented in three parts: *Principles of Pastoral Counseling, Preparation for Pastoral Counseling,* and *Resources for Pastoral Counseling.* A generous amount of illustrative clinical material is presented, which should interest many non-clergy counselors who may not realize how much *the new pastoral care* is now using records and clinical material.

Hiltner's description of the importance of the *pre-counseling contact* of the clergyman is especially interesting. The minister is the only professional person in the field of counseling who can go to the person who needs help and initiate treatment without having to wait for the sufferer to come to him. When properly used, this opportunity can be most significant in getting at emotional difficulties early.

Followers of Dr. Carl Rogers' "non-directive" (now called "client-centered") counseling will be stimulated by Hiltner's criticism of Dr. Rogers methods and his own description of what he calls "eductive counseling." Both these methods seem to me to be rigid and limited; both, however, are good correctives to counselors who are aggressive and directive.

This is a stimulating and exciting book to any one who is interested in personal counseling, which Mr. Hiltner describes as "an activity and not a profession."

RUSSELL L. DICKS.

Duke University

NOTES AND COMMENTS

World Federation for Mental Health to Meet in Paris

The Third Annual Meeting of the World Federation for Mental Health will be held in Paris, by kind invitation of the Ligue d'Hygiène Mentale, from Thursday, August 31, to Thursday, September 7, 1950, inclusive. Meetings will be held in the Cité Universitaire. This is situated south of the River Seine, overlooking the Parc de Montsouris, about three miles from the Place de la Concorde. The Cité Universitaire is served by the Metro (Underground) and by bus service.

Membership will consist of the delegation appointed in each country by the convening organizations, in conjunction with other member associations, where these exist; and, in addition, any other members of member associations who are able to attend the meeting.

The first six days—from August 31 to September 5, inclusive—will be devoted to the discussion of scientific topics, primarily in small working groups. At the suggestion of many members of the federation, it has been decided to limit to a minimum the number of plenary sessions in which communications will be made to the whole meeting, and to concentrate mainly on small international, interprofessional groups for discussion. The main topics to be considered are: (1) Mental Health in Education; (2) Occupational and Industrial Mental Health; (3) Mental-Health Problems of Transplanted and Homeless Persons; and (4) Problems of Leadership and Authority in Local Communities.

The administrative sessions of the meeting will be held on Wednesday and Thursday, September 6 and 7. It is hoped that each national delegation will be represented at these by at least one delegate, with authority to vote; but other members of member associations who are interested in the policy and business of the federation will also be warmly welcomed.

The sixth meeting of the executive board of the federation will be held from Sunday, August 27 to Wednesday, August 30; and the seventh meeting, on Friday and Saturday, September 8 and 9. These meetings will also take place in the Cité Universitaire.

A certain number of students' rooms in the Cité Universitaire will be available for those attending the meeting, and will be allocated by the secretariat of the federation in rotation, as requests for them are received. (Details of cost, and so on can be supplied by the Division of World Affairs, The National Committee for Mental Hygiene.) Early application should be made to the Secre-

tary of the Federation, 19 Manchester Street, London, W 1, as the number of rooms available will be limited. Hotel reservations should be made direct or through the usual travel agencies.

Bulletin of World Federation for Mental Health

The World Federation for Mental Health is making an effort to increase the subscription list of its bulletin. Though the number of subscribers is increasing, there are still not quite enough to make the English edition self-supporting, or to enable the federation to carry out its plan for a separate French edition.

We call this to the attention of our readers because we feel that there are many among them who would find the bulletin of interest. Issued bi-monthly, the bulletin has a twofold purpose: to serve as a link between the World Federation and its member associations, and to provide a forum for the exchange of ideas and information on the principles and practices of mental health throughout the world. Its aim is to be of value "not only to those professionally interested in the broad and multi-disciplinary field of mental health, but also to many others in wider circles. In short, it is hoped that the bulletin may play some part in making the pursuit of mental health a 'peoples' movement' in the fullest sense of the term."

The price of a yearly subscription is $1.00, which should be mailed directly to World Federation for Mental Health, 19 Manchester Street, London W1, England.

Twelfth International Penal and Penitentiary Congress

The Twelfth International Penal and Penitentiary Congress will be held at The Hague, Netherlands, August 13–19, 1950.

The following persons will be admitted to take part in the work of the congress: (1) delegates sent by governments; (2) members of parliaments, state councils, or equivalent bodies; (3) members of national academies; (4) professors, assistant professors, readers, and lecturers of faculties and universities; (5) high officials of the ministries or departments concerned; (6) higher officials of prison administrations; (7) members of the courts and tribunals; (8) advocates regularly entered at a bar; (9) delegates and members of penal and penitentiary societies and prisoners' after-care societies; (10) members of the committee that took part in the preparation of the congress; (11) persons who have become known by their scientific work in penal and penitentiary questions; and (12) persons invited for the purpose by the International Penal and Penitentiary Commission.

The amount of the registration fee is 20 Dutch guilders.

French and English are the official languages of the congress, and speeches made in one of these languages will be translated into the other language unless the assembly unanimously decides not to require translation. Any speaker may speak in another language if he is able to provide for the immediate translation of his speech into French or English.

Any further information about the congress may be obtained through the delegate of the United States Government on the International Penal and Penitentiary Commission, Mr. Sanford Bates, State Office Building, Trenton, New Jersey. In addition to being a delegate, Mr. Bates is also president of the congress.

Annual Meeting of the American Orthopsychiatric Association

Some 1,100 people attended the Twenty-seventh Annual Meeting of the American Orthopsychiatric Association, held in Haddon Hall, Atlantic City, New Jersey, on February 22, 23, and 24.

The meeting opened with a general session, at which the president of the association, Miss Marian McBee, of The National Committee for Mental Hygiene, gave the Presidential Address, taking as her subject, "Social Potentials in Orthopsychiatry." Other papers presented at this session were *Individual Therapy and Collective Reform: A Historical View,* by Crane Brinton, of Harvard, and *Value Judgments in Psychiatry,* by Sol W. Ginsburg, of New York City.

The remainder of the program consisted of twenty-six special sessions of papers and discussions on many aspects of orthopsychiatric work, both theoretical and practical, in a number of different fields. Also included were a showing of mental-hygiene films and a series of eight "case workshops," limited to groups of not more than thirty, at each of which a case history was presented and discussed. The entire series of cases, with an edited discussion of each, is to be published as a monograph during the coming year. A cocktail party and a dance made up the lighter side of the program.

Dr. H. Whitman Newell, Clinical Director of the Psychiatric Clinic of Baltimore, and associate professor of psychiatry at the University of Maryland, will be the president of the association for the year 1950–51. Dr. James M. Cunningham, Director of Detroit Children's Center, is president-elect. Other officers are: vice president, Miss Annette Garrett; secretary, Dr. Morris Krugman; and treasurer, Simon Tulchin.

The 1951 meeting of the association will be held in Detroit, February 22, 23, and 24. The 1952 meeting will again be held in Atlantic City the third week in February.

Annual Conference of American Group Therapy Association

The American Group Therapy Association held its Seventh Annual Conference at the Hotel New Yorker, New York City, on January 13 and 14, 1950.

The conference began with an evening session on January 13, at which Dr. Samuel B. Hadden delivered the presidential address, and Mr. S. R. Slavson presented a 50-minute movie on "Activity Group Therapy." The sessions on Saturday, January 14, were devoted to research problems and to reports on group therapy in special settings—a court clinic, a family agency, and so forth.

American Occupational Therapy Association to Meet in Colorado

The annual convention of the American Occupational Therapy Association will be held in Glenwood Springs, Colorado, October 16 to 20, 1950.

Medical authorities in the various fields will present new medical developments and discuss their application to occupational therapy. Exhibits of occupational-therapy materials and equipment will be displayed during the week.

The convention will be held at the Colorado Hotel.

Dr. Frederick Allen Wins Philadelphia Award

An honor that will give great pleasure to his friends and fellow workers in the field of mental hygiene was conferred upon Dr. Frederick H. Allen, Director of the Philadelphia Child Guidance Clinic, when, on February 21, he received the Philadelphia Award for 1949

This award, consisting of a sum of $10,000 and a medal, was established in 1921 by Edward W. Bok. It is given to the person who, in the opinion of its board of trustees, has during the past year performed some act or service of outstanding value to the city and its people. Dr. Allen is the twenty-seventh recipient of the award and the second psychiatrist to receive it. The first was Dr. Earl D. Bond, Director of Research and Training of the Institute of the Pennsylvania Hospital. Other distinguished winners of the award include Samuel W. Fels, Leopold Stokowski, Russell H. Conwell, and Thomas S. Gates.

The award was presented to Dr. Allen by Judge Herbert F. Goodrich, chairman of the board of trustees, at a dinner at the Barclay. Dr. Allen's acceptance of it as a tribute not merely to him, but to "a great staff," was more than a graceful gesture—it was a generous acknowledgment of a fact. The success of the Philadelphia Clinic is indeed due not only to a fine director, but

to a fine staff and to the splendid teamwork that has existed between them since the day, twenty-five years ago, when the clinic opened with the classical clinic unit—Dr. Allen as psychiatrist; Miss Almena Dawley, now associate director of the clinic, as psychiatric social worker; and Dr. Phyllis Blanchard as psychologist—to the present time, when it has the services of four staff psychiatrists, seven psychiatrists-in-training, twelve experienced psychiatric social workers and five social workers-in-training, and when child psychiatrists trained under its program are to be found in institutions scattered throughout the world.

We are sure that all readers of MENTAL HYGIENE will join us in warmest congratulations to Dr. Allen and his "great staff" for this well-deserved tribute to their work.

FELLOWSHIPS IN CHILD-GUIDANCE-CLINIC PSYCHIATRY AVAILABLE

The American Association of Psychiatric Clinics for Children announces the availability of specialized training in child-guidance-clinic psychiatry in a number of its member clinics approved as training centers by the association. This training begins at a third-year postgraduate level, with minimum prerequisities of graduation from medical school, a general or rotating interneship, and a two-year residency in psychiatry—all approved.

This training is in preparation for specialization in child psychiatry, and especially for positions in community clinics devoted wholly or in part to the outpatient treatment of children with psychiatric problems. At the completion of training, attractive openings are available in all parts of the country. Fellows receive instruction and supervision in diagnostic and therapeutic techniques with children, in the utilization of the integrated services of the psychiatric-clinic team, and in the coördination of clinic effort with the work of health, welfare, and educational agencies in the community. There is considerable variation in the different clinics, due to the fact that they are under different auspices and have various affiliations.

Most of the clinics plan for a two-year training period, although a few still accept one-year fellows, and a few others will consider giving one-year training in special cases.

Fellowship stipends are usually $3,000 for the first year of training and $3,600 for the second year, but may be more or less in certain instances, depending upon the status of the fellows and upon the practices of the individual training center. Funds for these stipends come from the Public Health Service, from the clinics that are giving the training, and in some cases from clinics or communities that are paying for the training of psychiatrists who

promise to work in these communities at the end of their training.

The office of the American Association of Psychiatric Clinics for Children gives information and assistance to applicants who seek this training. Application may be made through this office or directly to the individual clinics. In all cases, acceptance of applicants for training is by the individual training centers. In practically all instances, the work at these clinics has been credited by the American Board of Psychiatry and Neurology for a third year of training and for an additional year of experience.

For further information and for application forms, write to: Dr. A. Z. Barhash, Executive Assistant, American Association of Psychiatric Clinics for Children, 1790 Broadway (Room 916), New York 19, N. Y.

Scholarships in Psychiatric Nursing

Recognizing the need for more nurses trained in mental-health principles, the General Federation of Women's Clubs has approved a scholarship program for training psychiatric nurses at the Norton Memorial Hospital, Louisville, Kentucky. They hope that each state federation of women's clubs will provide one $500.00 scholarship to a registered nurse for a six-months course in the psychiatric unit of the hospital.

American Psychiatric Association Sets Up Clearing House of Hospital Information

The American Psychiatric Association is setting up a clearing house to exchange technical information among mental hospitals and other institutions that care for psychiatric patients in the United States and Canada. Announcing the plan, Dr. George S. Stevenson, president of the association, said, "This new service will bring to light the best practices of each hospital for the benefit of all, to the common end that more patients may be restored to their families and communities to lead normal, useful lives."

A monthly mental-hospital news bulletin will be the keystone of the service. The bulletin will report news of current developments in clinical practices, hospital administration, community relations, legislation, architectural planning, accounting, procedures, research, and any and all other types of information that will help the hospitals to improve patient treatment and care.

Austrian Universities in Need of Psychiatric Publications

The desperate need of Austrian universities for publications in the field of psychiatry and psychology has been called to our atten-

tion by a recent letter from Dr. Wally Reichenberg-Hackett, of the Department of Psychology, Duke University, who attended the First International Congress of Applied Psychology in Austria last summer. She writes:

> "May I call your attention to a message from the Austrian participants of the meeting? Being the only representative from the United States there, I was asked again and again to take to psychiatrists and psychologists an urgent request to assist in obtaining journals and reprints. Indeed, here we can scarcely realize the difficult circumstances under which work is carried on in Austria. It seems the University of Vienna has none of the journals and periodicals available, the use of which we take for granted. As you know, there is no money available to purchase books and journals. Reprints are at a premium. Students take lecture notes and study from them, and research workers grope around in despair.
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> "During the summer I visited both the University of Graz and the University of Innsbruck. The condition of the libraries is pathetic. Psychiatrists and psychologists begged for journals and reprints, current ones as well as back issues. They do not know what is going on in the field. Men who have had traveling fellowships and have been to the United States in recent years have reported on current research in this country and lectured on new developments. The interest is great. . . .
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> "At the end of the war, Graz was occupied by the Russians for several weeks. At present it is occupied by the English. Innsbruck is in the French Zone. Neither the English nor the French are able to do much for the universities in those cities, while many German universities are considerably helped by the Americans. As a consequence, the paucity of current literature in Graz and Innsbruck is appalling.
>
> "Could you assist by sending reprints and journals to these centers? Of course, books, too, would be most welcome."

We pass this request on to our readers. We are sure that anything they may send will be most gratefully received. Material should be sent to Dr. Eichinger, Psychologisches Institute, Universität Graz, Graz, Austria; or to Professor H. J. Urban, M.D., Neurologisch-psychiatriche Universität-Klinik, Innsbruck, Austria.

Preventive Work in Social Hygiene Still Important

A warning lest overconfidence in penicillin and the promise of quick cure of syphilis lead to a neglect of preventive measures for venereal-disease control is voiced in the recent annual report of the American Social Hygiene Association.

"One of our most important jobs in 1949," the report states, "was to convince people that penicillin has not solved the problem of venereal disease, still the most prevalent of serious communicable infections. The fact is that penicillin, while it cures most VD, does

not *find* cases, nor does it prevent the behavior which leads to infection and, too often, to reinfection. We must not slacken our efforts. We must maintain appropriations for VD control."

Last year the association's field staff studied prostitution conditions in 275 cities in 43 states and Alaska. Military authorities and health and law-enforcement officials received fully documented reports of the findings, particularly of demoralizing situations in communities near military concentrations.

Commenting on these findings, Dr. Walter Clarke, executive director of the association, said, "It is the American Social Hygiene Association's job to help communities correct such conditions. How can we expect our young soldiers, sailors, and airmen to be strong enough to protect our country in a crisis, and to become good citizens when they return to their home communities, if we expose them to moral and physical hazards while they are in the armed forces?"

The association's current research on the legal and social aspects of sex crimes included the publication, in a recent issue of the *Journal of Social Hygiene,* of a comprehensive study of the laws of 13 states and the District of Columbia dealing with the habitual sex offender. The organization is continuing its studies in this field.

An Essay Contest for High-School Seniors

An interesting project in the direction of interesting the coming generation in the mental-disease problem was an essay contest, open to seniors in the high schools of five states—Tennessee, Georgia, Florida, and North and South Carolina—on the subject, "What We Should Know About Mental Illness." The contest was sponsored by Dr. Orin R. Yost, Psychiatrist-in-chief at the Edgewood Sanitarium, Orangeburg, South Carolina, and promoted by the junior chambers of commerce of that state. The response was very encouraging, entries coming in from four states. The essays, not exceeding 1,000 words in length, were judged on comprehension of the subject, evidence of research, and originality of presentation.

The first prize—$250.00—was awarded to Nancy DePass, eighteen-year-old student of Camden, South Carolina. She received the award from Congressman Hugo S. Sims, Jr. at the ceremony that opened the neuropsychiatric seminar held recently at Edgewood. The second prize went to Caroline Hubbard, of Bushnell, Florida; and the third, to Bobbie Fuller, of Norlina, North Carolina. Two Orangeburg Negro students, Mary Rose Thompson and Maceo Gordon, submitted highly creditable essays and were named as honorable-mention winners.

Mental-Health Films

The National Mental Health Film Board reports that two of the films it is making for state mental-health authorities are now in production. One is on mental health in the schools; the other, on the mental health of older persons. Subjects to be covered by other films produced by the board this year include adolescence and fears of children.

Mental Health in Colleges

Any person or committee concerned with the health of college students will be interested in securing copies of *A Health Program for Colleges,* the report of the Third National Conference on Health in Colleges. The report makes recommendations for programs of mental health as well as for those in the other areas of college health.

The field of mental health in colleges has been relatively unexplored. Little is known of the mental-health problems that exist among the students in the majority of colleges, although it is estimated that 15 per cent of all college students could benefit from mental-hygiene services. Only a few of the larger or better endowed colleges provide for the services of psychiatrists or mental-hygiene clinics. It would seem that colleges should give futher consideration to their responsibility in this matter.

Copies of *A Health Program for Colleges* are available from the National Tuberculosis Association, 1790 Broadway, New York 19, New York, at $2.00 a copy.

News of Mental-Hygiene Societies

Compiled by

Marjorie H. Frank

Assistant Director, State and Local Organization, The National Committee for Mental Hygiene

California

More than 400 delegates attended the two-day annual conference of the Mental Health Society of Northern California, held on January 28 and 29. Conclusions presented at the final general session covered suggestions for mental health from childhood to old age.

Under the auspices of the society, Dr. Benjamin Spock gave two lectures to a Bay Area audience. Close to 1,200 people were crowded into the auditorium and over 500 people had to be turned away each

night for lack of space. A baby-sitters' agency sent its entire staff of 25 "sitters" to the Spock lecture and held a discussion about it afterward. Seven hundred and fifty members of various mothers' clubs also attended.

Two more county chapters have been affiliated with the society, making a total of 17 functioning chapters and one in process of reorganization.

The San Joaquin County Mental Hygiene Society informs us that Miss Eve Dalander is its new chairman. This society held a dinner meeting on March 22, at which Dr. Tallman, Director of the California State Department of Mental Hygiene, was the principal speaker. The society also reports that it has completed a survey pointing up the need for a community mental-hygiene clinic, and that it is presenting its data to the state department of mental hygiene.

Connecticut

Two new members have been elected to the Board of Directors of the Connecticut Society for Mental Hygiene—Dr. Milton J. E. Senn, Director of the Yale University Child Study Center, and Mr. Hiram Sibley, Executive Director of The Connecticut Hospital Association.

In December the revised bill for the child-study-and-treatment home, for which The Connecticut Society for Mental Hygiene has worked for more than six years, was passed by the state legislature, providing an appropriation of $120,000 for a pilot project for the skilled care of from nine to twelve children. This is only a beginning, but it is hoped that it will soon grow into a treatment center adequate to the great state-wide need. Plans are going forward rapidly for the establishment and operation of this child-study home, and Governor Bowles has appointed a seven-member board of trustees under the chairmanship of Dr. Senn.

At last report, 44 schools in Connecticut had purchased the script and discussion guide for the playlet, *The Ins and Outs,* and plans are going forward for a number of performances throughout the state.

On February 21, at the Repertory Theater in New Britain, a senior-high-school group, made up of junior members of the local experimental theater, presented the play for senior experimental-theater-group members and other interested guests at an evening performance. The same cast of students has given the play at the New Britain High School, and will arrange to give it in nearby schools before student audiences.

On February 3 and 4, the Greater Norwalk Chapter sponsored a two-day conference on "Mental Health—Everybody's Business," which was attended by approximately 500 people from various parts of the state. Two speakers were Dr. Lawrence K. Frank, who discussed "Mental Health—A Democratic Task," with special emphasis on the changing family to-day and the "symphony of services" offered by the community; and Mr. William Marvin, Guidance and Counseling Director of the Elizabeth Irwin High School in New York, whose subject was "Pressures on Our Children in Society To-day." The Norwalk Chapter, the youngest chapter of the Connecticut Society for Mental Hygiene, has combined enthusiasm and careful planning to make a fine community program.

Florida

The Mental Health Society of Southeastern Florida is endorsing the recommendations made by Dr. Guthrie, of the United States Public Health Service, in his preliminary report of the survey he made of Florida mental institutions. A tentative action program for the next two years has been planned by the society in relation to his recommendations.

The society was also active in remembering patients at the state hospitals at Christmas. They state that this was merely a beginning and they hope that next year this activity will be on a larger scale.

Illinois

The Illinois Society for Mental Hygiene reports that Governor Stevenson has appointed a committee of Illinois citizens to serve as a planning and advisory committee for The Mid-century White House Conference on Children and Youth. Mrs. Frank H. Woods, Jr., formerly an officer and member of the board of directors of the society, is chairman of the committee; and Mrs. Bernice T. Vander Vries and Dr. Marietta Stevenson, members, respectively, of the society's board of directors and advisory council, have been appointed members of the committee. Dr. Rudolph G. Novick, the society's medical director, is the committee's technical consultant.

As of January 30, 1950, Miss Maryan H. Brugger, recently appointed education secretary of the Illinois Society, took over the duties formerly executed by Mr. Louis deBoer, who left for Washington, D. C., the first of January.

The society reports further that the Sangamon County affiliate society is showing a unique competence in public relations. It has put on a busy and significant mental-hygiene program in Springfield.

Indiana

The Indiana Mental Hygiene Society gives the following as its major activities for the year: holding institutes for ministers, public-health nurses, and teachers; promoting the use of *The Ins and Outs* in the high schools in Indiana; planning study courses for the use of such groups as parent-teacher associations and church societies; and promoting a state-wide membership campaign and the education of the public through such means as radio programs, talks by staff and speakers' bureau, sale of pamphlets, seminars, public meetings, and so on. The society also plans to study needed changes in the commitment laws of the state in coöperation with the League of Women Voters, the mental-health authority of the state, and other interested persons.

During the last three months the society has started the organization of volunteer services and of a committee on mental hygiene in Indiana schools. The chairman of this committee is the dean of the School of Education of Indiana University, and the committee is made up of representatives of the state department of public instruction, the state association of elementary-school principals, the state teachers association, and the state congress of parents and teachers. It includes also the superintendents and principals of representative schools throughout the state. Plans are being made for a pilot institute for the in-service training of teachers in mental hygiene.

This society reports that *The Indiana Teacher*, a publication of the Indiana State Teachers Association, highly recommends *The Ins and Outs*. To quote:

> "It's just about the best thing a guidance teacher could ever hope to lay her hands on, to say nothing of dramatic coaches, home-room sponsors, camp leaders, counselors, or simply the harried teacher with next month's assembly on his mind. *The Ins and Outs* has only five characters, practically no props, and can be produced in a classroom almost as effectively as it can be produced on a stage. Its theme is 'belonging'—than which nothing is more important to a teen-ager—and its whole purpose is to help young people understand themselves. The fact that it does so without ever getting stuffy about it, or over-obvious or arty, is remarkable. The fact that it is also an excellent play, able to stand on its merits as a play entirely apart from its educational aspects, is something of a miracle."

The St. Joseph County Citizens' Society for Mental Health, a chapter of the Indiana Mental Hygiene Society, reports that, with the aid of contributions from individuals and church organizations, 150 hymnals were purchased and presented to the Logansport State Hospital for use by the patients in their chapel services.

Before Christmas the local group met and packed individual boxes

which were sent to 150 patients from St. Joseph County who had had no visitors during the year and who had no money in their canteen fund. Each box contained candies, cookies, gum, and a personal gift. Name cards were made out for each of the 150 patients and the packages were beautifully tied with Christmas paper and ribbons. The boxes were donated by the Campbell Paper Box Company of South Bend. The officials and the hospital, as well as the patients who received the gifts, were very appreciative and the assistant superintendent, Dr. Morrow, said that in his many years in hospital work he had never seen such a project undertaken.

In March the society held a joint meeting with the South Bend Chapter of the American Association of University Women. Dr. L. Potter Harshman, psychiatrist at the Fort Wayne State School for Feeble-minded Children, Fort Wayne, Indiana, was the principal speaker.

The April program, held on April 27, relates to National Mental Health Week. The Mayor of South Bend will issue a Mental Health Week Proclamation. The speaker for the meeting will be a representative of the Cleveland (Ohio) Council of Churches, who will talk on "How Ohio Changed Its Antiquated Laws," referring to laws relating to the care of the mentally ill of that state. There will also be a short review of Indiana's laws in regard to mental patients.

The May meeting will include a dinner for the members of the local organization and the election of officers. Mr. Walter W. Argow, Executive Director of the Indiana Mental Hygiene Society, will speak on "The Family of the Mentally Ill."

Maryland

The Mental Hygiene Society of Maryland sends in the following report:

> "Work is proceeding on the setting up of a new all-purpose mental-hygiene clinic in Baltimore. The Community Chest has agreed in principle to match public funds up to $25,000 to support such a clinic.
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> "The child-guidance branch of the society, composed of parents of mentally handicapped children, continues with monthly meetings of around 50. Dr. Lloyd N. Yepsen, Chief Psychologist of the Division of Classification and Education of the New Jersey Department of Institutions and Agencies, addressed the March meeting.
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> "The Service to the Mental Hospitals program continues to expand. Twenty-one previously screened and trained volunteers (occupational-therapy volunteer aides and social therapists) are receiving 20 hours of psychiatric orientation at Spring Grove State Hospital.
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> "The 30 volunteers in the Council of Jewish Women project are already at work at Rosewood State Training School. Some are under the supervision of the registered occupational therapist; most

are working with the recreational aides. Orientation there is being directed by Dr. Leslie Quant, educational director.

"A weekly Volunteer At Home started March 1 at the society's headquarters. These meetings are designed for office volunteers, members of organizations engaged in volunteer service, and new contacts who are waiting for another recruitment drive. Members of the American Association of Psychiatric Social Workers have planned and will conduct a mental-hygiene institute.

"On March 21, all organizations and individuals engaged in volunteer service at Spring Grove State Hospital were invited by the society to a Salute to Isabel Dinner to celebrate the first anniversary of Mrs. Isabel Schumann as coördinator of volunteer activities. Over 200 invitations were issued. The other guest of honor was Miss Margaret Dudley, who is celebrating her thirtieth year as a social worker at Spring Grove, and is one of the most enthusiastic supporters of the volunteer program.

"The public-education committee, under the chairmanship of Dr. Sibyl Mandell, has had two meetings to review mental-hygiene films. The group is now breaking up into functional subcommittees for such specific purposes as to screen pamphlets, radio programs, etc.; to set up training programs for volunteers; to plan a speakers' institute; to draw up a mental-hygiene discussion manual; to work with lay organizations requesting advice on mental-hygiene programs; etc.

"All the society's resources are pointing toward the membership drive in April. The goal is a membership of 10,000. The tools are 30,000 copies of a promotional folder and a 12-minute, 16 mm sound film, *Maryland's Mentally Ill*, most of which was shot on location at the mental institutions.

"Committees are being set up for concentrated work in the several professions, the state federation of women's clubs, labor, retail trade, the three major religious groups, etc. Interest is high. Requests for the film and for speakers are pouring in.

"Mental Health Week will be the peak of the campaign. Plans are being made which the society will sponsor jointly with the American Psychiatric Association and the Jaycees [junior chambers of commerce].

"A series of four mental-hygiene discussions is being planned for East Baltimore in April and May. Sponsors, besides the society, include the city health department, the Enoch Pratt Free Library, and the various community councils and child-welfare groups. Films, speakers, pamphlets, and reading lists are to be used.

"In the fall, six 6-session institutes are to operate simultaneously in strategic community centers in East Baltimore. This is one of the projects of the public-education committee.

"The Ner Israel Rabbinical College has asked the society to arrange a course in mental hygiene for its 100 theological students, and another for its adult-education program.

"The Mental Hygiene Committee of the Anne Arundel Lay Public Health Association held an open meeting in January to support a state appropriation for preventive mental hygiene. Over 200 people were present, and they later collected over 2,000 names to petitions sent to their representatives in the Senate and the House of Delegates.

"In March, this committee called a combination membership-volunteer-recruitment meeting. It has accepted responsibility for providing social-therapy volunteers to Crownsville State Hospital, the Negro institution. Applications were circulated among women's organizations, screening is to be done by professional social workers, and a 10-hour training program was planned. The volunteers are needed for arts and crafts in the wards of the hospital, which has no occupational-therapy department."

Massachusetts

The newsletter of the Massachusetts Society for Mental Hygiene announces that the society is building a library of mental-health films to be lent interested groups throughout Massachusetts. It also sent fifteen speakers to various communities in the state during January. The speakers for the most part were psychiatrists and members of the staff of the society.

A professionally oriented volunteer program in two state hospitals is being organized by the society through its assistant executive director, Mrs. Irene T. Malamud. Metropolitan State Hospital, one of the commonwealth's largest urban institutions for the mentally ill, and Foxboro, a smaller hospital in a more rural area, have already established hospital steering committees to administer the much-needed volunteer program.

Steering committees in each hospital consist of the heads of the social-service, occupational-therapy, nursing, and medical divisions, and the hospital steward. There is a paid director of volunteers who serves as liaison officer between the steering committee and the volunteers who are being recruited by the society. Emphasis is upon recruitment through civic organizations rather than individuals. Mrs. Malamud has already established liaison with groups in Waltham and Foxboro who have adopted state-hospital-volunteer programs as continuing projects. Though the local groups may do the first recruiting, the society screens the volunteers for work on the wards, in recreational activities, and outside the hospital, providing food for parties, clothes mending, and other activities.

"The work of these state-hospital volunteers is in reality professional," said Mrs. Malamud. "Volunteers should consider themselves as effective participants in the expansion of services in Massachusetts state hospitals."

As these projects develop, other state hospitals will be invited to expand their volunteer programs.

Dr. G. Colket Caner has been reëlected president of the Massachusetts Society, and five new persons have been elected to three-year terms on the board of directors.

Michigan

From the *Mental Hygiene Bulletin*, published quarterly by the Michigan Society for Mental Hygiene, we learn that Miss Martha E. Yackel joined the staff of the Michigan Society in January as consultant on community-mental-health programs. She will work with the chapters of the society and with other groups in planning and promoting such programs.

The Detroit Section of the National Council of Jewish Women coöperated with the society in planning a number of mental-hygiene meetings during the fall and early winter. The society's chapters are very active, particularly in community education. All have held meetings for the general public with excellent speakers. Many have presented radio series as well as mental-hygiene films, and have held mental-hygiene institutes. For example, the Bay County Chapter, in coöperation with the Bay City Council of Social Agencies, held a meeting for the general public at which Dr. John M. Dorsey, Chief of the Department of Psychiatry, Wayne University Medical School, Detroit, spoke on "Necessary Community Resources for a Mental-Health Program."

The Calhoun County Chapter presented a series of four stimulating meetings. Two of the subjects discussed were "Problems of the Alcoholic" and "Mental-Hygiene Aspects of Personnel Problems in Industry." This chapter also sponsored *The Inquiring Parent* radio series, arranged for a series of meetings for expectant parents, and developed a display board for exhibiting current mental-hygiene pamphlets and leaflets to various groups and organizations in their county.

The Steering Committee of the Genesee County Chapter has been quite active and a constitution and by-laws have been prepared.

The Kalamazoo County Chapter has been holding regular meetings of its board and at one meeting presented the mental-hygiene films, *Emotional Needs of Childhood, Over-Dependency, and Feelings of Hostility*. This chapter is suggesting the use of mental-health films, with competent discussion leaders, to other groups and organizations interested in mental health. It is formulating plans for another mental-hygiene institute in the spring. The board is also interested in volunteer services at the Kalamazoo State Hospital.

Kent County Chapter is working hard to stimulate public interest and support for the establishment of an adult psychiatric outpatient clinic with a full-time staff, and is sponsoring a series of articles on mental-health resources in the Grand Rapids press.

The Midland County Chapter has a new president, Dr. Harold L. Gordon, of Dow Chemical Company, who was elected after the

resignation of Mr. Nelson Merritt. The board has been holding regular meetings and showing mental-health films to the public and it is also arranging for radio broadcasts for a series of programs relating to child growth and development.

The Oakland County Chapter has arranged for a series of six mental-health meetings for members and the general public. Over 300 persons have attended the first three meetings. This chapter has purchased the Oregon film, *Human Growth*, for use by the chapter and other groups in the county.

Early in the fall the Wayne County Chapter sponsored a series of eight meetings for expectant parents, and because of the success of this program, another series was arranged for February. It also held a series of four lectures for the general public in February designed primarily to carry the mental-hygiene message to a wide audience. This program brought to Detroit a group of nationally known figures. Tickets for the series were $2.00, and it was a sell-out, 1,200 tickets being sold in advance of the first meeting.

Missouri

A report from the Missouri Association for Mental Hygiene states:

> "January and February of 1950 will be high-lighted in the history of the Missouri Association for Mental Hygiene by two events: one, the four-day visit by Marian McBee, and two, the launching of the playlet, *The Ins and Outs*, before 2,500 members and guests of the National Association of Secondary-School Principals on February 19. Produced in the Music Hall of Kansas City's Municipal Auditorium by students of Shawnee-Mission High School from adjacent Johnson County, Kansas, the playlet brought resounding applause from the audience. The following day brought from the principals a rush of orders for the packets of scripts and discussion guides. Of these orders, 59 have been filled, with 17 states as destination.
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> "With 750 flyers on *The Ins and Outs* distributed throughout the audience, and with National Committee pamphlet lists available at the Missouri Association for Mental Hygiene booth, it is reasonable to suppose that orders will continue to reach the offices of The National Committee for Mental Hygiene and the New York Committee on Mental Hygiene from states all over the nation.
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> "Mr. Joseph C. McLain, Principal of the Mamaroneck Senior High School, Mamaroneck, New York, in whose school the playlet was first worked out, added to the value of the Kansas City production by his introduction of the various mental-health purposes it served among his student body. The interest of both principals and guidance counselors carried over from *The Ins and Outs* to *Human Relations in the Classroom, Course II*, by H. Edmund Bullis; *Better Ways of Growing Up*, by J. E. Crawford and L. E. Woodward; and many of the later pamphlets.
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> "The January tour made by Marian McBee, Director of State and Local Organization, The National Committee for Mental Hygiene,

through Missouri included the annual meetings of the Kansas City Mental Hygiene Society, the St. Louis Society for Mental Hygiene, and a luncheon meeting with the Board of Directors of the Buchanan County Society in St. Joseph. At each of these meetings, Miss McBee counseled with the group on the state organization pattern now on demonstration in Missouri. This attempt to solve some of the geographical difficulties arising from the location of the two large centers of population at each end of a state four hundred miles in length, presents a constant challenge. Miss McBee's conferences, together with the new manual on organization (by McBee and Frank), are concrete evidence of the value to be derived from closer local, state, and national relationships.

"A workshop period conducted by Miss McBee in Kansas City on January 23, on 'How to Go About Organizing a Mental Hygiene Society,' was attended by representatives from four Missouri counties with ten or more persons from the two Kansas Cities. Local community differences, needs, and objectives came in for discussion. The relationship between local, state, and national mental-hygiene organizations and the need from the beginning for continuity in program and leadership, with emphasis on local mental-health education and state mental-hospital needs, were commonly agreed to be major goals."

New Jersey

The Mental Hygiene Society of Burlington County held a meeting last November of 30 key persons from various towns in the county, and appointed a nominating committee. At a second meeting, held in December, the following officers were elected: president, Mrs. William Grobler; vice president, Rev. W. E. Hogg; recording secretary, Mrs. H. J. Levy; corresponding secretary, Mrs. Martha P. Yancy; treasurer, Mr. Alex. Denbo.

This society reports that its program for the present will be focused on the orientation of all the society's members. It is hoped this will stimulate work in the county and in the county institutions.

The Mental Hygiene Committee of the Somerset County Council of Social Agencies reports that this committee continues to be a loosely formed group of about 35 persons. Its major objective for the year is continuance of an education program. Durng the last three months, it has sponsored a course of 12 lectures on "Fundamental Concepts of Modern Psychiatry," which was given by the staff of the Veterans Administration Hospital and was attended by 180 school principals, school-teachers, visiting nurses, and other professional people from Somerset County. A course of four lectures, on "Development of the Normal Personality," "Conflicts of Modern Living," and "Basic Factors in the Development of Behavior Disorders in Children," was attended by 60 parents from the P.T.A. groups in the county. About 15 single lectures on some phase of the preventive aspects of mental

hygiene were given to various clubs and civic groups in the county. The committee plans to hold additional single lectures for different county groups including an open council-of-social-agencies meeting at which H. Edmund Bullis, Executive Director of the Delaware Society for Mental Hygiene, will speak on "The Delaware Plan."

The Mental Hygiene Society of Union County reports its activities during the past three months as follows:

> "Members of the society's professional staff and members of the board delivered many talks at meetings of a large number of local social and civic organizations.
>
> "The first issue of our *Mental Health News* was published and distributed to a large number of lay and professional leaders and organizations throughout Union County.
>
> "We plan to sponsor presentation of American Theatre Wing plays in Cranford, Elizabeth, Summit, and Plainfield. In each instance the play will be supplemented by group discussion led by either a psychiatric social worker or a psychiatrist. (A psychiatrist will be the discussion leader in at least two or three of these discussions.)
>
> "We are presenting a seminar on personality development in Cranford in April, led by Dr. Raymond H. Gehl, a psychiatrist who is a member of our staff. This will include a series of five meetings.
>
> "A steering committee has been appointed for Mental Health Week and a membership drive will begin simultaneously."

New York

The Mental Hygiene Association of Westchester County reports in its *Mental Hygiene Bulletin:*

> "Mr. David Rauch, our educational director, has completed a series of discussion groups with students in the Rye High School. Forty boys and forty girls were divided into two mixed groups, and four discussions on various teen-age problems were held with each group. After the series was completed, questionnaires were distributed among the children, asking them how they liked the idea, what subjects they would have liked to discuss more fully, etc. Almost all the children wanted more such discussion groups and felt that schools should spend more time discussing everyday adjustments of students.
>
> "A three-session course on 'Father's Rôle in Child Development,' open only to fathers of children in the North White Plains Elementary School, was held recently, and to the surprise of no one, it was discovered that it is only because nobody pays any attention to them that fathers get left out of the talks, lectures, and demonstrations so eagerly attended by the mothers. Twenty-five fathers showed up for all the sessions, and had a fine time! Mr. and Mrs. David Sack planned the series.
>
> "At the November 7th board meeting, Mrs. Robert Austin, chairman of the program committee, presented a tentative plan for future meetings which would provide a constructive nucleus around which

each meeting might be built. Its main theme will be 'Mental Hygiene in Education.' At the January 9th meeting, Dr. Ruth Andrus, Chief of Child Development for the State Department of Education in Albany, discussed an ideal mental-health program in schools. This was a closed meeting—open only to the board itself—to orient ourselves on what can be done."

North Carolina

With the establishment of a central office, the North Carolina Mental Hygiene Society is in a position to give increasing services throughout the state. Communications should be addressed to Elsie L. Parker, executive secretary, P. O. Box 2599, Raleigh, N. C.

The president, vice president, and secretary-treasurer are elected at the annual meeting for a term of two years. There is a board of directors of 21 members who serve three-year terms, one-third of them being elected each year. The program of the society is carried out through nine committees: the committees on education, on legislation, on projects in training and research, on coöperation with hospitals, on the exceptional child, the liaison committee, the institute committee, the nominating committee, and the membership committee.

Ohio

The Cleveland Mental Hygiene Association states that it believes mental hygiene should be an integral part of the fabric of health and welfare services in the community. A few examples of cördination with the Welfare Federation shows that the director of the association serves on each of the following committees of the federation: the committee on alcoholism; the health-education committee of the health council; the legislative committee; the case-work council community-planning committee; the committee on social protection; the community planning subcommittee on children's aid society; and the occupational-planning subcommittee on the handicapped. The educational secretary of the association serves on the volunteer advisory committee and on the adult-education committee of the group-work council.

The following are specific examples of coördinated activity: In coöperation with the occupational-planning committee, the association planned and led the section conference of the Annual Health and Welfare Institute in 1949 on "Rehabilitation of the Mental and Physically Handicapped." It brought to the attention of the occupational-planning committee the acute shortage of trained occupational therapists and the large number of vacancies in the field. It assisted

in planning the psychiatric sessions of the federation-sponsored all-day institute on alcoholism. It participated in the planning for the program of the annual meeting of the social-hygiene committee, and has addressed the group-work council and discussed the mental-hygiene aspects of group-work practice. It has worked closely with state officials regarding the need for a coördinated volunteer program in Cleveland state hospitals, and as a result, Dr. Crawfis is giving favorable consideration to the possibility of employing a director of volunteer services.

The Cleveland Mental Hygiene Association staff and board have been available to the Welfare Federation staff and agencies for the discussion of mutual problems. Also, the federation staff have channeled valuable information and extremely helpful guidance to the Cleveland Association. Family service agencies and other welfare-federation agencies have been participating actively in the association's educational program by delegation of case-workers to meet requests to give talks and lead discussions on mental hygiene and parent-child relationships.

The Montgomery County Mental Hygiene Association held its annual meeting on March 13. The speaker for the evening was Dr. Daniel Blain, Medical Director of the American Psychiatric Association.

The society reports:

> "A committee on the retarded has just been established to study the needs and problems of this group and then attempt to formulate a program to help them. A committee on alcoholism has been spear-heading an educational and action program in the community to develop a total program of services to deal with the problem of chronic alcoholism. The hospital-service committee had much to do with making this Christmas the best one the patients ever had in the Dayton State Hospital. Plans are already lining up for the 1950 Christmas. This group is also taking the lead in organizing a state-hospital guild of women who can spend one or two half-days a month participating in social parties or teas with female patients. The first one was scheduled for February 22. About 50 club women have already become members of the guild. The speakers' bureau continues to receive calls for speakers. Eleven talks were given in January, seven of them by the executive secretary. The committee on adult counseling is preparing to study the amount and type of counseling services available and what might be done to improve these services in our area. The committee on institutes is already looking to next fall for the Fourth Annual Mental Hygiene Institute. Plans are going forward to establish a clinic on epilepsy for demonstration, consultation, and instructional purposes. This is being developed coöoperatively with the Ohio Society for Crippled Children."

Oregon

Recent activities of the Mental Health Association of Oregon are reported as follows:

> "The Mental Health Association of Oregon was fortunate in being able to reëmploy Mr. Harold Barton as field representative. Mr. Barton is well known in the field of mental health as a result of his association with the National Mental Health Foundation as one of the founders and at one time executive director. Mr. Barton is working intensively in the Willamette Valley (Eugene, Corvallis, and Albany). In addition to the 'routine' association activities, he is very successfully helping several organizations and agencies in the area to crystallize the need for and the possibility of developing an all-purpose mental-hygiene clinic in this area. Such a clinic is sorely needed as a treatment facility for children and adults, but even more acutely as a basis for the extended professional training of teachers, psychologists, social workers, etc. (It is to be noted that in Oregon there are no training facilities for social workers, clinical psychologists, or psychiatrists.) The success of this program has been enhanced by the fact that a psychiatrist has begun to establish a private practice in Eugene.
>
> "Mrs. Leon Fisher, a social worker, has joined the Mental Health Association of Oregon as a part-time educational assistant.
>
> "The association was pleased to be able to co-sponsor Oregon's Fifty-second Social Hygiene Day. Sponsored by the Mental Health Association of Oregon, the Brown Trust, the Oregon Tuberculosis and Health Association, and the state department of health, Social Hygiene Day was a work conference aimed at clarifying thinking as to a desirable 'Oregon Plan' for social hygiene. Mr. Melvin L. Murphy, director of the association, was convener and discussion leader for the professional counselors' groups.
>
> "Through coöperation with the state health department's division of mental hygiene and health education, both radio and film programs have been and will be made increasingly available to interested groups throughout the state. The association and the Community Child Guidance Clinic of Portland are stressing the development of improved types of study group in the community.
>
> "As a part of its program of assisting in the development of professional skills in Oregon, the association arranged a meeting with Mrs. Elizabeth De Schweinitz for some of the social workers of Portland. More such programs are anticipated for various types of personnel along with attempts, using *Hi, Neighbor!* as a point of departure, to interpret well-staffed local agencies, private and public, as basic mental-health resources."

Pennsylvania

Under a new constitution adopted in December, the Public Charities Association of Pennsylvania became the Pennsylvania Citizens Association for Health and Welfare. Owen B. Rhoads, Esq., was

elected president for the two-year term ending December, 1951. Dr. Frederick H. Allen continues as state chairman of the division on mental health. The new constitution provides that the board of directors and the division committees (for each of the four functional divisions) shall be representative of the entire state and shall meet in different parts of the state by geographical sections.

In addition to regular meetings of the southwest (Pittsburgh) and southeast (Philadelphia) sections, initial meetings of the sections in the Meadville-Erie section (northwest), the Harrisburg-York-Lancaster section (east central), the Wilkes-Barre-Scranton section (northeast), and the Reading-Easton section (mid-east) were held in the period from December to February. The section committees have appointed active steering committees to plan future programs and nominate section officers.

In February, Dr. Hilding A. Bengs, who was appointed last summer as commissioner for mental health, spoke to the division committee in Philadelphia on the mental-institution building program. By the end of 1952, it is hoped that most of the projects undertaken in the $140,000,000 building and improvements program will have been completed, thus relieving overcrowded conditions and eliminating the unsafe and unsanitary conditions so notorious at a few institutions when the program started. Dr. Louis J. Kowalski, of the bureau of mental health, also spoke at this meeting, telling of Pennsylvania's plans for the use of National Mental Health Act funds. Initially, these funds will be used almost entirely for strengthening present community-clinic facilities.

South Dakota

The South Dakota Mental Health Association is now actively promoting *The Ins and Outs* in every high school in the state.

The president of the association, Dr. E. S. Watson, attended a short course in child psychiatry at the University of Minnesota, and spent a day visiting the state training school in Plankington.

A legislative committee has been appointed by the association to study more adequate mental-health legislation and to help to secure sufficient appropriations from the legislation for South Dakota's state hospitals. An activities committee was also appointed, one of whose functions will be to set up a speakers' bureau.

Miss Marian McBee, of the National Committee for Mental Hygiene, visited the association in January to help with organizational and activity problems.

Texas

The Texas Society for Mental Hygiene reports:

"The immediate and long-range plans and budgets prepared by the newly created Board for Texas State Hospitals and Special Schools, together with the surveys and studies that preceded them, which have absorbed the attention and energies of the Texas Society for Mental Hygiene and the Governor's Citizens Committee on Mental Health for several months, were brought into sharp focus at a meeting of the latter organization on January 30, immediately preceding the opening of the special session of the state legislature called by Governor Shivers to consider these matters. Dr. Daniel Blain was the guest speaker-consultant for the meeting. Upon adjournment, the members went in a body to the state capitol to present to the governor resolutions commending the board for its plans and policies in the state's care of the mentally ill, and pledging continued support of all efforts toward the improvement of mental health in Texas. We are glad to report that the legislature took favorable action on the board's recommendations, and increased certain tax levies to provide funds for the immediate budget requests. Long-range financing will be taken up in the regular session of 1951.

"There will be close coöperation between the junior chamber of commerce and this society at the state and local levels in planning for National Mental Health Week.

"The Austin-Travis County Society for Mental Hygiene was privileged to present Dr. Daniel Blain as guest speaker at an open meeting, and to hear an inspiring presentation of the functions of a local mental-hygiene society—to carry on comprehensive surveys of conditions in those areas which affect the mental and physical well-being of those in the community.

"The Lubbock County Society sponsored a series of lectures by Dr. R. K. O'Laughlin, psychiatrist, which is stimulating much interest in the society, and the admission charge of $1.00 for all or any part of the series is putting the treasury in a better position to carry on its program.

"Because of inclement weather, the Tarrant County Society for Mental Hygiene conducted one of its monthly programs by radio. A panel discussion of 'Mental Health Means All of Us' proved highly successful. Participants included two psychiatrists, three psychologists, and a sociologist.

"New memberships and renewals attest the value of the series of lectures by local psychiatrists on emotional patterns which the society is continuing throughout the spring.

"The Galveston Mental Health Society's attractive sheet, *News*, which was made possible by a local printing company, carries chatty comments to its members on matters pertaining to mental hygiene throughout the community. Among the notes is an account of a one-day joint meeting of teachers and counselors of a junior high school with a team composed of the city school superintendent, a practicing psychiatrist, a psychiatric nurse, and the director of the local child-guidance clinic. This was a local society's application of the statewide project, 'Mental Health in Education.'

"The Tom Green County Society for Mental Hygiene reports the presentation of Mrs. Grace Sloan Overton, who conducted a panel on 'Youth and Their Community Needs' at a luncheon meeting in San Angelo. Fifty leaders of youth groups and social workers participated. At another meeting, the membership learned of the workshop for parents and teachers being conducted in the San Angelo Public Schools. The major objective of this society is the education of its members on specific needs in the community.

"In two metropolitan areas, members of the state society are actively engaged in developing interest in county mental-hygiene societies; and the organization of affiliated study groups is being considered in a state teachers college and a city council of church women."

Virginia

The Mental Hygiene Society of Virginia has sent us a copy of the annual report presented by Mr. Gwaltney, executive secretary, at the Thirteenth Annual Meeting of the society and its thirteen local chapters, on February 13. We note that this society, in coöperation with the department of mental hygiene and hospitals, has effectively availed itself of the opportunity to make wide distribution of pamphlets and booklets. A directory of mental-hygiene facilities in Virginia was also continued and widely distributed. Again in coöperation with the department of mental hygiene and hospitals, the society has been quite active in promoting the use of a selected group of films on mental health and emotional problems. The selection was made from the point of view of helping parents, school-teachers, and children. The showing of the films has been state-wide through the past year.

Many well-attended meetings have been held. The society feels that the outstanding event of the past year was the organization of the Richmond Chapter of the Mental Hygiene Society of Virginia, and it is hoped that new chapters will be organized during the coming year.

The Northern Virginia Mental Hygiene Society reports that Dr. Henry Work spoke on "Meeting the Emotional Needs of Children" at the December meeting of the society's program committee. Dr. Robert Burnham spoke on conditions at Western State Hospital in connection with an official visit of 21 citizens and officials representing the State of Virginia Mental Hygiene Society, who toured state institutions officially. A lecture and discussion by Dr. Sidney Berman, on "The Challenge of the Teen-Ager," was held at the January meeting.

This society reports that a committee has been set up to determine the adequacy of commitment facilities for children under sixteen who are suffering from epilepsy, cerebral palsy, or mental retarda-

tion. The committee also plans to determine the adequacy of community facilities for these children.

The publicity committee is planning to publish a news release, summarizing local, state, and national news on mental health.

This society is planning for special activities on Mental Health Week and a continuance of interesting discussions at its monthly meetings.

Wisconsin

The Wisconsin Society for Mental Health writes that it is encouraging, but proceeding slowly with, the establishment of county mental-health societies. It wants to feel sure that the county groups really wish to undertake a constant program at the local level.

The society reports:

> "Our objectives for the year, as announced at the annual meeting by the president of the society, Milton C. Borman, M.D., of Milwaukee, are: (1) establishment of a sound financial structure; (2) organization of county units as rapidly as the state organization can service them properly and the local strength and seriousness of purpose is assured; and (3) continuing responsibilities which include area meetings presenting civic responsibility for mental health, in which local talent and hospital staff unite in presenting an over-all account; promotion of interest in proper administration of mental-health laws revised and modernized by the 1947 State Legislature; encouragement of mental-health emphasis in community programs in related fields; maintenance of intelligent interest in the administration of state tax-supported services at an optimal level of efficiency; and immediate response to inquiries of all types relating to mental-health facilities, state and local.
>
> "The directors are at present acting as a committee of the whole on State Mental Health Month (April) and (National) Mental Health Week programs. We have been able to set up a maximum coverage and responsibilities have been allocated. Several members of the board of directors are already scheduled to appear on live broadcasts and to participate in discussions on tape recordings as well as to address groups.
>
> "A special committee is undertaking a study of insurance, compensation, and prolonged recovery. A preliminary survey indicates that the study may be of exceptional value as a part of the industrial-community-educational-service program of the society.
>
> "The committee on legislation has been expanded in function to include responsibility for continuous study and report on administration of the tax-supported mental-health services.
>
> "The story of the films in the production of which the society has been interested for many months was told by Allen B. Gates, Director of Training of the Eastman Kodak Company, at the Personnel Conference of the American Management Association in Chicago, February 14. The films constitute concrete evidence to top management and others that practical information on difficulties caused by 'harm-

> ful worry' on the job can be safely presented to foremen. The information is technically sound and is sufficiently safeguarded. It provides needed and positive help in situations that must largely be handled, at least initially, by immediate supervision, but that are inconsistently and frequently unfortunately handled at present through lack of understanding.''

The Milwaukee County Society for Mental Health, reports that its incorporation papers were signed in December, and in January a twenty-one-member board of directors was elected as well as four officers. Most of this society's activities, since its first annual meeting in November, have been with the reorganization of the committee into a society. Several of its work committees—the library committee, the committee on mental-health education in schools, the volunteer committee, the institutions-entertainment committee, and the committee on institutional-service units—have all been very active. The institutions-entertainment committee arranged parties for Christmas and Valentine's Day. The committee on institutional-service units has made arrangements with the county board of public welfare for a 1950 institutional-service unit at Milwaukee County Asylum. Twelve college students will be accepted for a period of three months, starting June 15, 1950. An institutional-service-unit meeting was sponsored in December by this society and the Wisconsin Welfare Council. The outcome of the meeting was the formation of a Wisconsin Institutional Service Unit Alumni Association, with the purpose of strengthening the institutional-service-unit movement.

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